

# Best practice statements are not intended to dictate an exclusive course of management

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*Response to:* Mathur PP. Recognizing sperm DNA fragmentation testing in clinical evaluation of male fertility. *Transl Androl Urol* 2017;6:S681-2.

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Dr. Mathur in his commentary (1) responding to the practice recommendations for Sperm DNA Fragmentation (SDF) testing based on clinical scenarios by Agarwal *et al.* (2) asked a relevant question: Why did the Practice Committee of the American Society for Reproductive Medicine, in its committee opinion about the ‘Diagnostic evaluation of the infertile male’ (3), state that the routine use of SDF testing for the male partner of an infertile couple is not warranted?

Dr. Mathur highlighted the fact that there is a bulk of literature suggesting an association between SDF results and reproductive outcomes, which would *per se* support the incorporation of SDF testing to the male infertility workup. In our proposed guidelines, we reviewed the existing literature and contextualized the utility of SDF testing in specific clinical scenarios using evidence-based medicine (2). Notwithstanding, it is important to recognize that not all clinical practice guidelines (CPG) and best practice statements (BPS) are developed in the same way. And these documents tend to be conservative in their statements as they are primarily intended to help healthcare practitioners to enhance the quality of healthcare deliverable to patients. Equally important, CPG and BPS should discourage ineffective interventions during the medical evaluation and management.

Usually, a panel of experts containing a few members develops guidelines. Not always the methods concerning data collection, extraction, and interpretation is provided, nor is the inclusion of patient representative common (4,5). The ASRM practice committee opinion is not different. A

panel of fifteen members, mostly comprised of reproductive endocrinologists, developed the guideline (3). Notably, a single urologist is listed among the participants.

Despite being conservative in its statement related to the use of SDF testing, the ASRM BPS add “Because the prognostic clinical value of DNA integrity testing may not affect the treatment of couples, the routine use of DNA integrity tests in the clinical evaluation of male-factor infertility is controversial” (3). Notably, new evidence has emerged after publication of these guidelines in 2015, especially concerning the potential benefit of using testicular in preference over ejaculated sperm for ICSI among couples whose male partner has high SDF (6-8). As a matter of fact, clinical practice guidelines are evolving documents, and timely review and updates are part of their essence.

Lastly, CPG and BPS are not intended to dictate an exclusive course of treatment, as this has been indicated in a usual accompanying disclaimer. Other management and treatment strategies may be appropriate, taking into account the available resources, the patient needs, and specific practice conditions. As elegantly discussed by Greenhalgh and colleagues, delivery of care should be characterized by expert judgment rather than mechanical rule following. These authors go further by providing other important advice for healthcare practitioners, namely, ‘decisions should be shared with patients through meaningful conversations’ (9). In essence, the primary objective of any CPG should be to translate the best evidence into practice

and serve as a framework for standardized care while maintaining clinical autonomy and physician judgment.

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### Footnote

*Conflicts of Interest:* The authors have no conflicts of interest to declare.

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