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Original Research Article

From niche to norm: a 13-year single-centre retrospective analysis of oocyte cryopreservation trends in modern India

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ABSTRACT

Background: Oocyte cryopreservation (OC) has moved from a niche, largely medically-indicated procedure toward a mainstream fertility preservation option, but India-specific outcome data remain limited. This study aimed to describe demographic trends, oocyte yield, cycle repetition, and utilization patterns among women undergoing planned OC at a single Indian fertility IVF unit over a 13-year period.
Methods: A retrospective cohort of 62 women who underwent planned OC between January 2013 and January 2026 was analysed. Age, indication, number of stimulation cycles, MII oocyte yield, and utilization status were recorded. Appropriate descriptive and inferential statistics were used, including comparison of pre- and post-COVID periods.
Results: The cohort comprised 62 patients undergoing 70 stimulation cycles, predominantly for elective/social indications (85.5%), with oncofertility accounting for 14.5% of cases. The most common age group was 30-34 years (32.3%), with a mean yield of 6.2 ± 4.1 MII oocytes per patient. Oocyte yield declined significantly with age (Spearman $\rho = -0.26$, $p = 0.041$). The annual rate of patients undergoing OC increased approximately 4-fold in the post-COVID era (rate ratio 4.00, 95% CI 2.21-7.25, $p<0.001$). Only 9.68% of patients underwent repeated stimulation cycles, with the highest proportion of repeat cycles occurring in the 34-36-year age group. However, utilization of cryopreserved oocytes remained low (9.7%, 95% CI 3.6-19.9%).
Conclusions: Our study highlights positive shifting trends even in a developing country like India, where oocyte cryopreservation is evolving as an accepted method for fertility preservation. Societal challenges, myths, and financial limitations underscore the low utilization rates, emphasizing the need for strengthened education and support to empower women in planning their reproductive journeys.

Keywords: Oocyte cryopreservation, Egg freezing, Fertility preservation, India, COVID-19, Utilization rate

INTRODUCTION

Reproductive timelines have shifted substantially over the past two decades, as increasing numbers of women pursue higher education, career development, and financial stability before starting a family.[1,2] In parallel, improved survival following cancer diagnosis and treatment has brought fertility preservation into mainstream clinical practice.[3] Oocyte cryopreservation (OC), commonly known as egg freezing lies at the intersection of medicine, ethics, economics, and societal transformation, offering women the option to preserve reproductive potential ahead of anticipated age-related or treatment-related decline.

Egg freezing was considered experimental until the early 2010s, when advances in vitrification technique markedly improved post-thaw oocyte survival compared with earlier slow-freezing protocols.[4] Vitrification reduces ice-crystal

formation during freezing, better preserving the oocyte's delicate meiotic spindle apparatus. Following this technical improvement, the American Society for Reproductive Medicine (ASRM) removed the experimental label from oocyte cryopreservation in 2012-2013, formally recognizing it as an established clinical procedure and paving the way for its use in both medical and elective (social) context.[5]

Indications for OC now span elective fertility preservation for age-related decline, oncofertility prior to gonadotoxic cancer treatment, preservation ahead of surgery for endometriosis or in the context of autoimmune or genetic conditions affecting ovarian reserve, banking related to male-factor infertility circumstances, donor oocyte programmes, and fertility preservation for transgender individuals prior to gender-affirming treatment.[3]

Across all these indications, outcomes are governed principally by two factors: the patient's age at the time of freezing, and the number of mature (metaphase II) oocytes banked, since egg freezing pauses rather than reverses the biological effects of reproductive aging. Despite growing clinical uptake, India-specific data on oocyte cryopreservation remain limited.[2] This study provides a comprehensive overview of oocyte cryopreservation in India by evaluating the demographic profile of women undergoing the procedure, age-related oocyte yield, annual procedural trends, utilization rates, and evolving practice over a 13-year period, while also examining temporal changes before and after the COVID-19 pandemic.

METHODS

Study design and setting

This retrospective study was conducted at a single-centre IVF unit of a tertiary care fertility centre in New Delhi, India. The study was done over a period of 13 years from January 2013 to January 2026. The medical records of all eligible patients were retrieved. The data of patients' demographic characteristics, age at which retrieval was done, number of cycles done by individual patient, mature oocytes retrieved per cycle, and utilization of these oocytes were obtained from medical records. For analysis of changing trends, patients were further grouped into a pre-COVID period (January 2013-December 2019) and a post-COVID period (January 2020-January 2026).

Variables

For each patient, the following were recorded: age at cryopreservation, indication for freezing, number of ovarian stimulation cycles undertaken, total number of mature (MII) oocytes cryopreserved, utilization rate, number of egg freezing cycles per year, number of repeated cycles, and changing trends of OC over the study period.

Statistical analysis

Data analysis was conducted using SPSS v25 (IBM Corp., Armonk, NY, USA). This retrospective observational study used descriptive statistics to summarise participant characteristics, reporting continuous variables as mean ± standard deviation (SD) or median (interquartile range, IQR) and categorical variables as frequencies and percentages.

Normality was assessed using the Shapiro-Wilk test. Because oocyte yield was non-normally distributed, Spearman correlation and the Kruskal-Wallis test were used as the primary methods for assessing its association with age; Pearson correlation and linear regression are additionally reported for comparability with prior literature. Categorical comparisons used Fisher's exact test. To compare patient volume and trends of OC over the years, the cohort was divided into a pre-COVID period (January 2013-December 2019) and a post-COVID period (January 2020-January 2026); patient volume was compared as a person-time-adjusted rate (patients per year), given the differing duration of each period, and tested using an exact binomial test. Statistical significance was set at $p<0.05$.

RESULTS

The cohort comprised 62 patients undergoing 70 total ovarian stimulation cycles between 2013 and 2026 (Table 1). The majority of patients underwent oocyte cryopreservation for elective/social reasons (n=53, 85.5%), while 9 patients underwent fertility preservation for oncological indications (n=9, 14.5%).

Table 1: Cohort characteristics and oocyte yield by indication

Indication	N (%)	Mean Age (yrs)	Mean MII±SD
Social	53 (85.5%)	36.1	6.2±4.36
Onco-fertility	9 (14.5%)	25.4	6.1±1.90
Total	62 (100.0%)	34.5	6.2±4.1

N (%) = number of patients (percentage of total cohort, N=62); SD = standard deviation; MII = metaphase II oocyte. Between-group comparison of oocyte yield by Kruskal-Wallis test: H = 0.63, p = 0.427 (not statistically significant).

Patients aged 17–47 years underwent oocyte cryopreservation, with a mean age of 34.5 ± 5.6 years (median 35.0, IQR 32.0–38.0) (Table 2).

Mean oocyte yield was 6.2 ± 4.1 MII oocytes per patient (median 5.0, IQR 3.0–8.0, range 1–23) (Table 3). When stratified by age, oocyte yield was highest in women aged 30–34 and 35–37 years, both averaging 7.7 oocytes per cycle, before declining thereafter to 4.1 oocytes in the 38–40-year group and 3.8 oocytes in women aged 41 years and above (Table 3, Figure 1). This age–oocyte yield relationship was statistically significant, confirmed by both the Spearman correlation ($\rho = -0.261$, $p=0.041$) and the Kruskal–Wallis test across age groups ($H=11.03$, $p=0.026$).

Table 2: Descriptive statistics for age and oocyte yield

Variables	N (%)	Mean ± SD	Median (IQR)	Range
Age (years)	62 (100.0)	34.5±5.6	35.0 (32.0-38.0)	17-47
MII oocytes frozen	62 (100.0)	6.2±4.1	5.0 (3.0-8.0)	1-23

SD = standard deviation; IQR = interquartile range; MII = metaphase II oocyte.

The number of women opting for oocyte cryopreservation showed a clear rising trend over the study period, increasing from 1 patient in 2013 to a peak of 14 patients in 2023 (Table 4, Figure 2). This uptake accelerated markedly following the COVID-19 pandemic, with the annual rate of patients rising from 2.00 patients/year in the pre-COVID period (2013–2019) to 8.00 patients/year in the post-COVID period (2020–2026), representing an approximately 4-fold increase (rate ratio 4.00, 95% CI 2.21–7.25, $p<0.001$).

Table 3: Age-stratified oocyte yield and utilization

Age Group (yrs)	N (%)	Mean Age	Mean MII±SD	Median MII	Utilized, N (%)
<30	10 (16.1)	25.0	5.4±1.96	5.5	0 (0.0)
30-34	20 (32.3)	32.8	7.7±4.13	7.5	2 (10.0)
35-37	13 (21.0)	36.0	7.7±5.68	6.0	1 (7.7)
38-40	13 (21.0)	38.9	4.1±2.66	3.0	1 (7.7)
41+	6 (9.7)	43.3	3.8±1.72	4.0	2 (33.3)

N (%) = number of patients per age group (percentage of total cohort, N=62); MII = metaphase II oocyte; SD = standard deviation; Utilized, n (%)=patients within the age group who returned to use their cryopreserved oocytes. Spearman correlation between age and oocyte yield: $\rho = -0.261$, $p=0.041$; Kruskal-Wallis test across age groups: $H = 11.03$, $p=0.026$.

Table 4: Annual patient volume and oocyte yield, 2013-2026

Years	Period	N Patients (%)	Mean MII Oocytes
2013	Pre-COVID	1 (1.6)	1.00
2014	Pre-COVID	2 (3.2)	6.50
2015	Pre-COVID	5 (8.1)	4.00
2016	Pre-COVID	1 (1.6)	2.00
2019	Pre-COVID	5 (8.1)	5.40
2020	Post-COVID	8 (12.9)	4.75
2021	Post-COVID	3 (4.8)	5.00
2022	Post-COVID	9 (14.5)	6.67
2023	Post-COVID	14 (22.6)	8.36
2024	Post-COVID	12 (19.4)	5.83
2026	Post-COVID	2 (3.2)	10.50

N Patients (%) = number of patients per year (percentage of total cohort, N=62). Pre-COVID period spans 2013-2019 (7.0 years, 14 patients [22.6%], rate 2.00 patients/year); post-COVID period spans 2020-2026 (6.0 years, 48 patients [77.4%], rate 8.00 patients/year); rate ratio 4.00 (95% CI 2.21-7.25, $p<0.001$, exact binomial test). Linear regression of mean MII oocytes on year: slope = 0.386 oocytes/year, $R^2 = 0.091$, $p = 0.017$.

Table 5: Distribution of stimulation cycles per patient

Number of Cycles	N Patients (%)
1	56 (90.3)
2	4 (6.5)
3	2 (3.2)
Total	62 (100.0)

Total repeat-cycle rate (>1 cycle) = 9.68% (6/62). Of the 6 patients with repeat cycles, the highest proportion occurred among women aged 34-36 years (5 of 6, 83.3%).

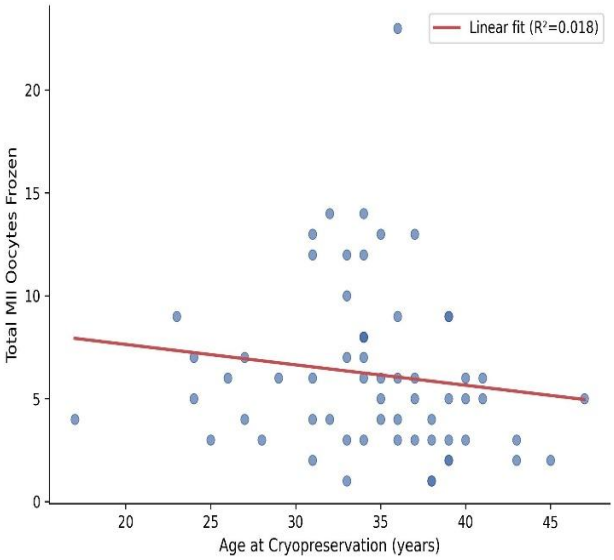

Figure 1: Oocyte yield (total MII oocytes frozen) versus age at cryopreservation, with linear fit shown for reference.

MII = metaphase II oocyte. Linear fit shown for descriptive purposes; the age-yield association was assessed formally using Spearman correlation (ρ = -0.261, p = 0.041; see Table 3).

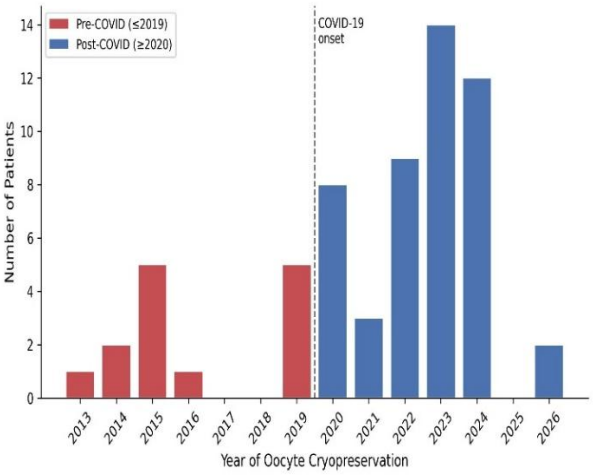

Figure 2: Annual patient volume, 2013-2026, with COVID-19 pandemic onset marked.

Pre-COVID = 2013-2019; post-COVID = 2020-2026. Rate ratio 4.00 (95% CI 2.21-7.25, p<0.001); see Table 4.

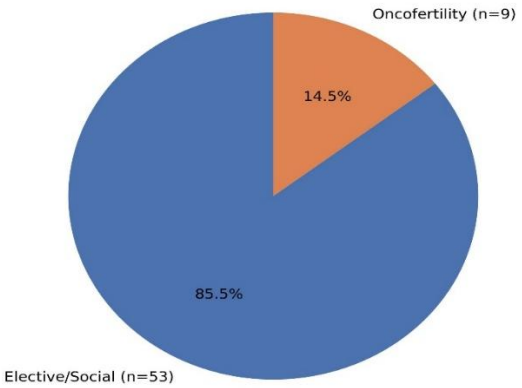

Figure 3: Distribution of indications for oocyte cryopreservation (n=62).

Social = elective/social fertility preservation; Oncofertility = fertility preservation prior to gonadotoxic cancer treatment. See Table 1.

Patients aged <30 years accounted for 16.1%, while those aged 41 years and above accounted for 9.7% (Table 3, Figure 4). Overall, 6 of 62 patients (9.7%) underwent repeat stimulation cycles; 4 patients (6.5%) underwent a second cycle and 2 patients (3.2%) underwent a third cycle (Table 5, Figure 5). The highest proportion of repeat cycles occurred among women aged 34–36 years, who accounted for 5 of the 6 patients (83.3%) with more than one stimulation cycle. Overall, 6 of 62 patients (9.7%; 95% CI 3.6–19.9%) returned to utilize their cryopreserved oocytes (Table 3). Two of the six patients (33.3%) utilized their eggs before the pandemic (pre-2020), while the remaining four (66.7%) did so during or after 2020.

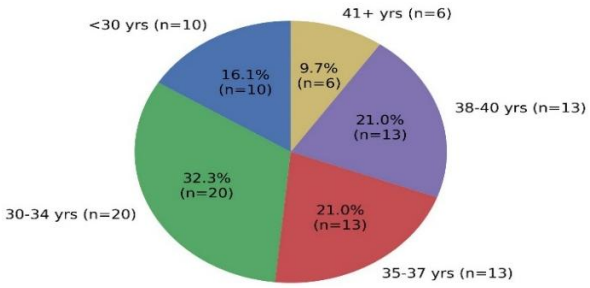

Figure 4: Age distribution of patients undergoing oocyte cryopreservation (n=62).

Age groups as defined in Table 3.

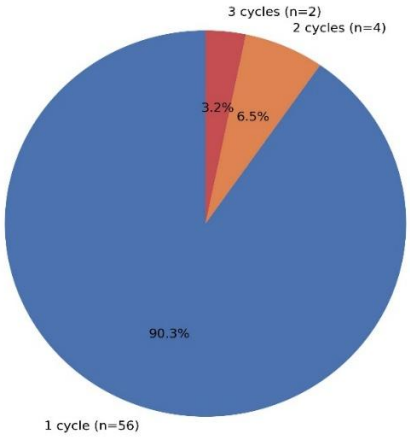

Figure 5: Distribution of stimulation cycles per patient (n=62).

See Table 5 for corresponding percentages and age-group breakdown of repeat cycles.

DISCUSSION

This 13-year single-centre study provides one of the longest Indian experiences of oocyte cryopreservation (OC), demonstrating five key findings: a significant age-related decline in mature oocyte yield, increasing utilization of both elective and oncological fertility preservation, a marked rise in the number of women undergoing OC in recent years, lower utilization rate of cryopreserved oocytes, and progressive improvement in oocyte yield over time. Together, these findings reflect the growing acceptance of fertility preservation in India while highlighting the importance of timely counselling and improved access to fertility preservation services.

The most robust finding of this study was the significant decline in mature oocyte yield with advancing maternal age, with peak retrieval observed between 30 and 37 years followed by a sharp reduction thereafter. This finding is consistent with the well-established physiology of ovarian ageing, whereby progressive follicular depletion, declining oocyte quality, mitochondrial dysfunction, and increasing aneuploidy result in reduced reproductive potential. Similar observations have been reported by Cobo et al, Goldman et al, Doyle et al and Cil et al all of whom demonstrated that both the number of mature oocytes retrieved and the probability of achieving a future live birth decline substantially with advancing maternal age.[4,8-10] Consequently, the number of oocytes required to achieve at least one live birth increases progressively after the age of 35: Chronopoulou et al estimate that 8-15 mature oocytes are needed under 35 years for a 60-70% projected chance of live birth, rising to 15-20 oocytes beyond 35 years.[11]

These findings reinforce current ASRM recommendations that planned oocyte cryopreservation is most beneficial when performed before 35 years of age, while recognizing that the procedure remains an option for appropriately counselled women at older ages as well.5 The mean age at cryopreservation in our cohort (34.5 years) lies close to this recommended window; however, nearly 10% of women underwent OC after 40 years of age, when both oocyte yield and cumulative live birth probability are substantially reduced. These findings highlight the need for earlier fertility counselling, enabling women to make informed reproductive decisions before age-related decline becomes clinically significant.

An interesting observation was that women younger than 30 years did not demonstrate the highest oocyte yield. This is likely explained by the composition of this subgroup, in which 80% of women underwent fertility preservation for oncological indications. Increasing evidence suggests that cancer itself, even before exposure to chemotherapy or radiotherapy, may adversely affect ovarian reserve. A recent systematic review by Wu et al demonstrated significantly lower anti-Müllerian hormone levels and antral follicle counts among reproductive-aged women with cancer compared with healthy controls prior to treatment.[6] Although our study did not demonstrate a statistically significant difference in oocyte yield between oncology and elective OC patients (Kruskal-Wallis $H = 0.63$, $p = 0.427$), the relatively small number of oncology patients likely limited statistical power.

The presence of an oncofertility subgroup in our cohort also reflects increasing awareness of fertility preservation among both oncologists and patients. International guidelines now recommend that all reproductive-aged patients facing potentially gonadotoxic therapy should receive timely counselling regarding fertility preservation before treatment commences.[3] Advances such as random-start ovarian stimulation have further facilitated timely oocyte retrieval without delaying cancer treatment, making fertility preservation increasingly feasible even in urgent clinical settings. These developments represent an important shift towards incorporating reproductive health into comprehensive cancer care.

Another important finding was the marked increase in the number of women undergoing oocyte cryopreservation over the study period, with an almost four-fold increase in annual procedures after 2020. While this temporal increase should not be interpreted as a direct consequence of the COVID-19 pandemic, indeed, Huttler et al found that only 15.2% of surveyed women reported that the pandemic altered their likelihood of considering oocyte cryopreservation.[12] It likely reflects the growing awareness and acceptance of fertility preservation among Indian women in recent years. Similar trends have been reported internationally, driven by delayed marriage, prolonged education, career aspirations, financial independence, improved success rates with vitrification, and greater public awareness of age-related fertility decline.1,2 The predominance of elective indications (85.5%) further supports the transition of oocyte cryopreservation in India from a niche fertility preservation strategy to an

increasingly accepted component of reproductive planning.

Despite increasing uptake, utilization of cryopreserved oocytes remained low (9.7%), consistent with international data reporting similarly low return rates: Lee et al in a national SART-CORS cohort with 5-7-year follow-up, reported a return rate of only 5.7%,13 while Klein et al in a single-centre cohort with a minimum four-year follow-up, reported a somewhat higher rate of 10.4%.[14] Importantly, utilization rates should be interpreted cautiously, as many women who recently underwent cryopreservation have not yet attempted conception. Studies with longer follow-up have reported substantially higher utilization rates, suggesting that low utilization often reflects insufficient follow-up rather than treatment failure.[15] Nevertheless, barriers unique to developing countries including financial constraints, lack of insurance coverage, limited awareness, and persistent misconceptions surrounding IVF and fertility preservation may also contribute to delayed or absent utilization.[2] Improving public education and ensuring affordable access to fertility preservation services remain important priorities in India.

Only 9.7% of women in our cohort underwent repeat stimulation cycles despite growing evidence that cumulative oocyte number, rather than a single retrieval, largely determines the probability of future live birth. Age-specific predictive models demonstrate that women freezing after 35 years frequently require multiple stimulation cycles to achieve the recommended number of mature oocytes associated with optimal live birth rates.[4,8,9,11] However, repeat cycles remain challenging in the Indian setting owing to substantial out-of-pocket costs, lack of insurance reimbursement, treatment burden, time constraints, and persistent social stigma surrounding assisted reproduction.[2] These findings emphasise the importance of counselling women that a single stimulation cycle may not always provide the optimal number of oocytes required to maximise future reproductive success.

Encouragingly, mean oocyte yield increased significantly throughout the study period. This likely reflects progressive advances in ovarian stimulation protocols, individualized treatment strategies, laboratory expertise, and vitrification techniques rather than changes in patient characteristics alone.[7] Similar improvements in oocyte cryopreservation outcomes have been described internationally with the widespread adoption of vitrification and continual refinements in assisted reproductive technology.[16,17] The increasing oocyte yield observed in our centre mirrors these global advances and reflects the temporal improvement of clinical and laboratory practice over time.

This study's strengths include its extended 13-year observation period, capture of both elective and oncological indications within a single cohort, and longitudinal assessment of temporal trends across the pre- and post-COVID transition reflecting the growing adoption of oocyte cryopreservation in modern India in recent years. Additionally, it reports utilization and repeat-cycle data, a dimension that remains scarce in the Indian fertility preservation literature.

Certain limitations should be acknowledged. The retrospective single-centre design may limit generalisability, while the relatively small oncology subgroup restricted meaningful comparisons between indication groups. Furthermore, utilization rates are likely underestimated because women undergoing cryopreservation in recent years have had considerably shorter follow-up than earlier cohorts. Information regarding ovarian reserve markers, pregnancy outcomes following oocyte utilization, live birth rates, and patient-reported reasons for non-utilization was also unavailable.

CONCLUSION

Our study highlights notable trend variations in reproductive planning among women in India, even within the context of a developing country. Oocyte cryopreservation has evolved considerably over the past 13 years, with an almost four-fold increase in annual procedures following the COVID-19 pandemic, reflecting the growing acceptance of fertility preservation among Indian women in recent years.

This mirrors changing global trends, where an increasing number of women are encouraged to optimise their reproductive choices and preserve their future fertility, with elective indications now accounting for the substantial majority (85.5%) of procedures in our cohort. In contrast, utilization of cryopreserved oocytes remained low (9.7%), a finding that will need to be specifically addressed through improved financial accessibility, expanded insurance coverage, and greater public education; analysis of these factors will further aid strategic resource planning going forward. Our study underscores the positive, shifting dynamics of fertility preservation in a developing country like India, where oocyte cryopreservation is increasingly evolving into an accepted and mainstream reproductive strategy. Societal challenges, persistent myths, and financial limitations likely continue to underlie the low utilization rates observed, emphasising the need for strengthened education, earlier counselling, robust oncofertility referral pathways, and sustained support to empower women in planning their reproductive journeys.

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