Supplemental material - Table 1. Search history of Medline search strategy *

	Search term	Number of records
1	(infertility treatment$ adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	17
2	(infertility treatment$ adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	8
3	(fertility treatment$ adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	8
4	(fertility treatment$ adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	2
5	(assisted reproduct$ adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	13
6	(assisted reproduct$ adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	27
7	((reproduct$ technolog$ or reproduct$ technique$) adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	13
8	((reproduct$ technolog$ or reproduct$ technique$) adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	23
9	(in vitro fertili?ation adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	59
10	(in vitro fertili?ation adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	33
11	(IVF adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	118
12	(IVF adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	85
13	(intracytoplasmatic sperm injection adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	0
14	(intracytoplasmatic sperm injection adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	0
15	(ICSI adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	29
16	(ICSI adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	19
17	(intra uterine insemination adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	2
18	(intra uterine insemination adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	0
19	(IUI adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	8
20	(IUI adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	10
21	(embryo transfer treatment adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$	0

	or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	
22	(embryo transfer treatment adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	0
23	(ovulation induction adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	14
24	(ovulation induction adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	14
25	(ovarian stimulation adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	10
26	(ovarian stimulation adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	21
27	((fertility or reproduc$) and (ART adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$))).ab,ti.	11
28	((fertility or reproduc$) and (ART adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in))).ab,ti.	21
29	((fertility or reproduc$) and (ART treatment adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$))).ab,ti.	0
30	((fertility or reproduc$) and (ART treatment adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in))).ab,ti.	0
31	((fertility service$ or infertility service$) adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	2
32	((fertility service$ or infertility service$) adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	1
33	((fertility therap$ or infertility therap$) adj5 (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$)).ab,ti.	0
34	((fertility therap$ or infertility therap$) adj5 (continu$ or stay$ in or persist$ or persever$ or compliance or comply$3 or complied or carry$ on or go$ on or keep on or kept or remain$ in)).ab,ti.	3
35	exp Reproductive Techniques, Assisted/ and opt out.ab,ti.	1
36	((infertility treatment$ or fertility treatment$ or assisted reproduct$ or reproduct$ technolog$ or reproduct$ technique$ or in vitro fertili?ation or IVF or intracytoplasmatic sperm injection or ICSI or intra uterine insemination or IUI or embryo transfer treatment or ovulation induction or ovarian stimulation) adj5 opt out).ab,ti.	0
37	exp Reproductive Techniques, Assisted/ and Patient Dropouts/	44
38	exp Reproductive Techniques, Assisted/ and Decision Making/ and (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$).ab,ti.	25
39	Infertility, Female/dt, th and Decision Making/ and (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$).ab,ti.	1
40	Infertility, Male/dt, th and Decision Making/ and (dropout$ or "drop$ out$" or discontinu$ or end or ended or ending or stop$ or terminat$ or withdraw$ or withdrew or abandon$ or quit$ or attrition or leav$ or left or ceas$ or halt$ or suspend$ or finish$).ab,ti.	1
41	Infertility, Female/dt, th and Patient Dropouts/	5
42	Infertility, Male/dt, th and Patient Dropouts/	1
43	or/1-42	518
44	limit 43 to (humans and yr="1978-Current")	476
*The following Medline search strategy was adapted for use with the other databases noting that Medline has the most superior search capabilities so not all terms or search strings can be used in the other databases		

Supplemental material – Table 2. Reasons for exclusion of full manuscripts screened and not included in systematic review

Manuscript	Reason*
Novel advances in IVF continue worldwide. Reproductive BioMedicine Online 2005; 10: 734.	1
Abdelmassih R, Dhont M and Comhaire F. Pilot study with 120 mg Andriol treatment for couples with a low fertilization rate during in-vitro fertilization. Human Reproduction 1992; 7: 267-268.	1
Abdelmassih R, Sollia S, Moretto M and Acosta AA. Female age is an important parameter to predict treatment outcome in intracytoplasmic sperm injection. Fertility & Sterility 1996; 65: 573-577.	1
Aboulghar MMA. The effect of intramural fibroids on the outcome of IVF. Middle East Fertility Society Journal 2004; 9: 263-267.	1
Agard ESW. The limits of reproductive technology: who decides? The Journal of clinical ethics 1999; 10: 329-332.	1
Agarwal A, Ranganathan P, Kattal N, Pasqualotto F, Hallak J, Khayal S and Mascha E. Fertility after cancer: a prospective review of assisted reproductive outcome with banked semen specimens. Fertility and Sterility 2004; 81: 342-348.	1
Agnani GG. Influence of Chlamydiae serology and the presence of a pelvic inflammatory state on the results of in-vitro fertilization. Revue Francaise de Gynecologie et d'Obstetrique 1991; 86: 327-330.	1
Akyuz A. Reasons for infertile couples to discontinue in vitro fertilisation (IVF) treatment. J Reproductive & Infant Psychology 2009 Aug. 27.	2
Alborzi S, Motazedian S, Parsanezhad ME and Jannati S. Comparison of the effectiveness of single intrauterine insemination (IUI) versus double IUI per cycle in infertile patients. Fertility and Sterility 2003; 80: 595-599.	1
Alviggi C, Revelli A, Anserini P, Ranieri A, Fedele L, Strina I, Massobrio M, Ragni N, De PG, Alviggi C, et al. A prospective, randomised, controlled clinical study on the assessment of tolerability and of clinical efficacy of Merional (hMG-IBSA) administered subcutaneously versus Merional administered intramuscularly in women undergoing multifollicular ovarian stimulation in an ART programme (IVF). Reproductive Biology & Endocrinology 2007; 5: 45.	1
Ambe AKR. Fertilization rate ratio analysis as a protective variable for the success of an in vitro fertilization program. Ginecologia y Obstetricia de Mexico 2003; 71: 16-24.	1
Antoine JM. [GnRH antagonists in insemination : can we avoid weekends?]. [French]. Journal de gynecologie, obstetrique et biologie de la reproduction 2004; 33: 3S50-53S52.	1
Bainbridge J. Male infertility and emotional wellbeing. Br J Midwifery 2007 Nov. 15.	1
Baird DT, Collins J, Cooke I, Cohen J, Evers JLH, Glasier A, Nieschlag E, Van Steirteghem A, Vercellini P, Mishell DR, et al. Optimal use of infertility diagnostic tests and treatments. Human Reproduction 2000; 15: 723-732.	1
Baird DT, Crosignani PG, Evers JLH, Fanchin R, Fauser BC, Filicori M, Jacobs H, Tarlatzis B, Cohen J, Diczfalusy E, et al. Mono-ovulatory cycles: a key goal in profertility programmes. Human Reproduction Update 2003; 9: 263-274.	1
Beckman LJ. Current Reproductive Technologies: Increased Access and Choice? [References]. Journal of Social Issues 2005; .61.	1
Beerendonk CH. The influence of dietary sodium restriction on anxiety levels during an in vitro fertilization procedure. Journal of Psychosomatic Obstetrics and Gynaecology 1999; 20: 97-103.	2
Belaisch-Allart J, De MJ, Lapousterle C, Mayer M and De Mouzon J. The effect of HCG supplementation after combined GnRH agonist/HMG treatment in an IVF programme. Human Reproduction 1990; 5: 163-166.	1
Belker AMC. Sperm processing and intrauterine insemination for oligospermia. Urologic Clinics of North America 1987; 14: 597-607.	1
Benjamin O. Rewriting fertilization: Trust, pain, and exit points. [References]. Women's Studies International Forum 2002; .25.	1
Ben-Shlomo I, Geslevich J and Shalev E. Can we abandon routine evaluation of serum estradiol levels during controlled ovarian hyperstimulation for assisted reproduction? Fertility and Sterility 2001; 76: 300-303.	1

Manuscript	Reason*
Bevilacqua K, Barad D, Youchah J and Witt B. Is affect associated with infertility treatment outcome? Fertility & Sterility 2000; 73: 648-649.	2
Biljan MM, Mahutte NG, Tulandi T and Tan SL. Prospective randomized double-blind trial of the correlation between time of administration and antiestrogenic effects of clomiphene citrate on reproductive end organs. Fertility & Sterility 1999; 71: 633-638.	1
Boden J. When IVF treatment fails. Human Fertility 2007 Jun. 10.	5
Boeckxstaens A, Devroey P, Collins J and Tournaye H. Getting pregnant after tubal sterilization: surgical reversal or IVF? Human Reproduction 2007; 22: 2660-2664.	1
Boivin J and Verhaak CM. Psychological interventions and pregnancy rates. Dropouts-random or non-random. Fertility & Sterility 2000; 74: 1261-1262.	6
Branco ACA. In vitro fertilization and embryo transfer in seminatural cycles for patients with ovarian aging. Fertility and Sterility 2005; 84: 875-880.	1
Braverman AM. Issues involved in the decision to end infertility treatment: When is enough enough? In Session-Psychotherapy in Practice 1996; 2: 85-96.	6
Brucker C and Berg D. IVF in minimally stimulated cycles: A low risk protocol with good patient compliance. Ixth World Congress on in Vitro Fertilization and Assisted Reproduction 1995: 247-250.	1
Bryan A. The psychosocial effects of infertility and the implications for midwifery practice. MIDIRS Midwifery Digest 2000 Mar. 10.	1
Callan VJ, Kloske B, Kashima Y and Hennessey JF. Toward understanding women's decisions to continue or stop in vitro fertilization: the role of social, psychological, and background factors. Journal of in Vitro Fertilization & Embryo Transfer 1988; 5: 363-369.	2
Calleri LF, Taccani C and Porcelli A. [Role of capacitation in intrauterine insemination as a treatment of male infertility]. [Italian]. Minerva Ginecologica 2001; 53: 347-350.	1
Check JH, Davies E and Adelson H. A Randomized Prospective-Study Comparing Pregnancy Rates Following Clomiphene Citrate and Human Menopausal Gonadotropin Therapy. Human Reproduction 1992; 7: 801-805.	2
Check ML, Yuan W, Check JH, Swenson K, Lee G and Choe JK. Cumulative probability of pregnancy following IVF with ICSI and fresh or frozen embryo transfer. Archives of Andrology 2002; 48: 5-7.	1
Chedid S, Camus M, Smitz J, Van Steirteghem AC and Devroey P. Comparison among different ovarian stimulation regimens for assisted procreation procedures in patients with endometriosis. Human Reproduction 1995; 10: 2406-2411.	1
Chu MCP. Assessing the treatment efficacy of IVF with intracytoplasmic sperm injection in human immunodeficiency virus-1 (HIV-1) serodiscordant couples. Reproductive BioMedicine Online 2005; 10: 130-134.	1
Clapp DN. Helping patients know when 'enough is enough'. Sexuality, Reproduction and Menopause 2004; 2: 159-162.	1
Cohen JJ. Ovarian stimulation prior to in vitro fertilization using decapeptyl administered long-term. Contraception Fertilite Sexualite 1989; 17: 903-906.	1
Collins JA and Hughes EG. Pharmacological Interventions for the Induction of Ovulation. Drugs 1995; 50: 480-494.	1
Comhaire F, Depypere H and Millingos S. Statement on intra-uterine insemination. International Journal of Andrology 1995; 18: 76-77.	1
Comhaire FM. The effective cumulative pregnancy rate of different modes of treatment of male infertility. Andrologia 1995; 27: 217-221.	1
Comhaire FZ. Critical evaluation of the effectiveness of different modes of treatment of male infertility. Andrologia 1996; 28: 31-35.	1
Coney PG. Methods of ovulation induction. The Nebraska medical journal 1990; 75: 18-22.	2
Coombes R. BMA calls for continuted restrictions on use of IVF. BMJ (Clinical research ed 2004). 329: 1066.	1

Manuscript	Reason*
Corea G. What the king can not see. Women & health 1987; 13: 77-93.	1
Correy JF, Watkins RA, Bradfield GF, Garner S, Watson S and Gray G. Spontaneous pregnancies and pregnancies as a result of treatment on an in vitro fertilization program terminating in ectopic pregnancies or spontaneous abortions. Fertility & Sterility 1988; 50: 85-88.	1
Corson SL and Batzer FF. Homologous artificial insemination. Journal of Reproductive Medicine 1981; 26: 231-242.	2
Corson SLB. The cervical cap for home artificial insemination. The Journal of reproductive medicine 1986; 31: 349-352.	2
Croucher CA, Lass A, Margara R and Winston RM. Predictive value of the results of a first in-vitro fertilization cycle on the outcome of subsequent cycles. Human Reproduction 1998; 13: 403-408.	2
David G, Czyglik F, Mayaux MJ, Martin-Boyce A and Schwartz D. Artificial insemination with frozen sperm: protocol, method of analysis and results for 1188 women. British Journal of Obstetrics & Gynaecology 1980; 87: 1022-1028.	2
Dawson AA, Diedrich K and Felberbaum RE. Why do couples refuse or discontinue ART?. [Review] [51 refs]. Archives of Gynecology & Obstetrics 2005; 273: 3-11.	1
Daya S and Daya S. Life table (survival) analysis to generate cumulative pregnancy rates in assisted reproduction: are we overestimating our success rates?. [Review] [27 refs]. Human Reproduction 2005; 20: 1135-1143.	6
De Brucker MH. Cumulative delivery rates in different age groups after artificial insemination with donor sperm. Human Reproduction 2009; 24: 1891-1899.	2
de La RE, Quelen C, Peikrishvili R, Guibert J, Bouyer J, de La Rochebrochard E, Peikrishvili R, Guibert J and Bouyer J. Long-term outcome of parenthood project during in vitro fertilization and after discontinuation of unsuccessful in vitro fertilization. Fertility & Sterility 2009; 92: 149-156.	2
de La RE, Soullier N, Peikrishvili R, Guibert J, Bouyer J, de La Rochebrochard E, Soullier N, Peikrishvili R, Guibert J and Bouyer J. High in vitro fertilization discontinuation rate in France. International Journal of Gynaecology & Obstetrics 2008; 103: 74-75.	2
de Ziegler D, Gayet V, Aubriot FX, Fauque P, Streuli I, Wolf JP, De Mouzon J and Chapron C. Use of oral contraceptives in women with endometriosis before assisted reproduction treatment improves outcomes. Fertility and Sterility 2010; 94: 2796-2799.	1
Depa M, Pawelczyk L, Taszarek-Hauke G, siak M, Derwich K, Jedrzejczak P, Pawelczyk L, Taszarek-Hauke G, siak M, Derwich K, et al. [The effect of smoking on infertility treatment in women undergoing assisted reproduction cycles]. [Polish]. Przeglad lekarski 2005; 62: 973-975.	1
Dickey RP, Olar TT, Taylor SN, Curole DN and Matulich EM. Relationship of Endometrial Thickness and Pattern to Fecundity in Ovulation Induction Cycles - Effect of Clomiphene Citrate Alone and with Human Menopausal Gonadotropin. Fertility and Sterility 1993; 59: 756-760.	1
Dickey RP, Taylor SN, Lu PY, Sartor BM, Rye PH and Pyrzak R. Risk factors for high-order multiple pregnancy and multiple birth after controlled ovarian hyperstimulation: results of 4,062 intrauterine insemination cycles. Fertility and Sterility 2005; 83: 671-683.	2
Domar AD. Impact of psychological factors on dropout rates in insured infertility patients. Fertility and Sterility 2004; 81: 271-273.	6
Egbase PE, al-Sharhan M, al-Mutawa M, al-Othman S and Grudzinskas JG. Mimicking the high levels of activity of a large in-vitro fertilization unit leads to early success at the commencement of an in-vitro fertilization and embryo transfer programme. Human Reproduction 1996; 11: 2127-2129.	1
Eijkemans MJ, Heijnen EM, de KC, Habbema JD, Fauser BC, Eijkemans MJC, Heijnen EMEW, de Klerk C, Habbema JDF and Fauser BCJM. Comparison of different treatment strategies in IVF with cumulative live birth over a given period of time as the primary end-point: methodological considerations on a randomized controlled non-inferiority trial. Human Reproduction 2006; 21: 344-351.	1

Manuscript	Reason*
El-Nemr A, Al-Shawaf T, Sabatini L, Wilson C, Lower AM and Grudzinskas JG. Effect of smoking on ovarian reserve and ovarian stimulation in in-vitro fertilization and embryo transfer. Human Reproduction 1998; 13: 2192-2198.	1
Emery JA, Slade P and Lieberman BA. Patterns of progression and nonprogression through in vitro fertilization treatment. Journal of Assisted Reproduction & Genetics 1997; 14: 600-602.	2
Erel CTS. Exogenous gonadotropin therapy and intrauterine insemination: The role of etiology and prognostic factors. Middle East Fertility Society Journal 1998; 3: 145-153.	1
Eskandar MA. Does the addition of a gonadotropin-releasing hormone agonist improve the pregnancy rate in intrauterine insemination? A prospective controlled trial. Gynecological Endocrinology 2007; 23: 551-555.	1
Farr SL, Anderson JE, Jamieson DJ, Warner L and Macaluso M. Predictors of pregnancy and discontinuation of infertility services among women who received medical help to become pregnant, National Survey of Family Growth, 2002. Fertility and Sterility 2009; 91: 988-997.	2
Feichtinger W. Continuing the debate on the obvious need for milder forms of ovarian stimulation. Human Reproduction 1997; 12: 1837-1838.	6
Fernandes L. Fertility treatment. Nursing Standard 1999 25 Aug. 13.	1
Ferraro F, Costa M, Ferraiolo A, Anserini P, Remorgida V and Capitanio G. Intrauterine insemination with husband's semen as alternative to other assisted reproduction techniques. Acta Europaea fertilitatis 1995; 26: 63-67.	2
Ferring AGB. Optimal use of infertility diagnostic tests and treatments. Human Reproduction 2000; 15: 723-732.	1
Flisser E, Copperman AB, Flisser E and Copperman AB. Why do couples drop-out from IVF treatment? Human Reproduction 2009; 24: 758-759.	6
Freour T, Jean M, Mirallie S, Langlois ML, Dubourdieu S and Barriere P. Predictive value of CASA parameters in IUI with frozen donor sperm. International Journal of Andrology 2009; 32: 498-504.	1
Frydman R. Overview of cancellations between November 2004 and March 2005 at the Antoine-Beclere hospital. Journal de Gynecologie Obstetrique et Biologie de la Reproduction 2005; 34: 5S10-15S13.	2
Fujii S, Sagara M, Kudo H, Kagiya A, Sato S and Saito Y. A prospective randomized comparison between long and discontinuous-long protocols of gonadotropin-releasing hormone agonist for in vitro fertilization. Fertility & Sterility 1997; 67: 1166-1168.	1
Fukuda M, Fukuda K, Andersen CY and Byskov AG. Right-sided ovulation favours pregnancy more than left-sided ovulation. Human Reproduction 2000; 15: 1921-1926.	1
Fukuda M, Fukuda K, Andersen CY and Byskov AG. Ovulation jumping from the left to the right ovary in two successive cycles may increase the chances of pregnancy during intrauterine insemination and/or in vitro fertilization natural cycles. Fertility and Sterility 2006; 85: 514-517.	1
Gleicher N, Vanderlaan B, Karande V, Morris R, Nadherney K and Pratt D. Infertility treatment dropout and insurance coverage. Obstetrics & Gynecology 1996; 88: 289-293.	2
Gnoth C, Maxrath B, Skonieczny T, Friol K, Godehardt E and Tigges J. Final ART success rates: a 10 years survey. Human Reproduction 2011; 26: 2239-2246.	1
Goldfarb JM. Reproduction technology: what's really going on? Ohio medicine : journal of the Ohio State Medical Association 1988; 84: 789.	1
Goverde AJ, McDonnell J, Vermeiden JP, Schats R, Rutten FF and Schoemaker J. Intrauterine insemination or in-vitro fertilisation in idiopathic subfertility and male subfertility: a randomised trial and cost-effectiveness analysis. Lancet 2000; 355: 13-18.	3
Greil A. Help-seeking patterns among subfecund women. J Reproductive & Infant Psychology 2004 Nov. 22.	1
Greenfeld DA, Lavy G, Greenfeld DG, Holm CT and DeCherney AH. Helping Patients End Treatment - the Ivf Follow-Up Clinic As A Tool for Continuing Psychological-Assessment. Advances in Assisted Reproductive Technologies 1990: 959-964.	1

Manuscript	Reason*
Greil A. Infertility and psychological distress: a critical review of the literature. Social Science & Medicine 1997 Dec. 45.	1
Guerif FS. Efficacy of IVF using frozen donor semen in cases of previously failed DI cycles compared with tubal infertility: A cohort study. Reproductive BioMedicine Online 2004; 9: 404-408.	2
Guzick DS, Wilkes C, Jones HW, Jr. and Jones HWJ. Cumulative pregnancy rates for in vitro fertilization. Fertility & Sterility 1986; 46: 663-667.	2
Haan G, Bernardus RE, Hollanders HM, Leerentveld BA, Prak FM and Naaktgeboren N. Selective drop-out in successive in-vitro fertilization attempts: the pendulum danger. Human Reproduction 1991; 6: 939-943.	3
Hammarberg K. Stress in assisted reproductive technology: implications for nursing practice. Human Fertility 2003 Feb. 6.	1
Hammarberg K, Astbury J and Baker H. Women's experience of IVF: a follow-up study. Human Reproduction 2001; 16: 374-383.	2
Harrison RF, Hannon K, Keogh I, Aherne J, Faez R, Barry-Kinsella C, Lawless B, O'Rourke M, Doorly E and Walsh M. In vitro fertilisation and allied techniques. The initial experiences of the first Irish service. Irish Journal of Medical Science 1989; 158: 43-47.	2
Hershlag A, Kaplan EH, Loy RA, DeCherney AH and Lavy G. Heterogeneity in patient populations explains differences in in vitro fertilization programs. Fertility & Sterility 1991; 56: 913-917.	2
Hogan JW, Scharfstein DO, Hogan JW and Scharfstein DO. Estimating causal effects from multiple cycle data in studies of in vitro fertilization. Statistical Methods in Medical Research 2006; 15: 195-209.	1
Hoppe SI. The relationship between psychological distress, received social support, and in vitro fertilization outcome. Dissertation Abstracts International: Section B: The Sciences and Engineering.57.	2
Humphrey MH. Marital relationships in couples seeking donor insemination. Journal of Biosocial Science 1987; 19: 209-219.	3
Hynes GJ. The psychological well-being of infertile women after a failed IVF attempt: The effects of coping. British Journal of Medical Psychology.65.	1
Imoedemhe DA, Wafik AH and Chan RC. In vitro fertilization in women with "frozen pelvis": clinical outcome of treatment. Fertility & Sterility 1988; 49: 268-271.	1
Jacobs NN. A bibliotherapy approach for treating the psychological sequelae of infertility. Dissertation Abstracts International: Section B: The Sciences and Engineering 5219; .64.	2
Kainz K. The role of the psychologist in the evaluation and treatment of infertility. Women's Health Issues 2001; 11: 481-485.	1
Kamel MAA. Laparoscopic ovarian re-electro cautery versus ovulation induction with FSH for persistant anovulation after laparoscopic PCOS treatment. Middle East Fertility Society Journal 2004; 9: 70-78.	1
Kim CH, Cho YK and Mok JE. Simplified ultralong protocol of gonadotrophin-releasing hormone agonist for ovulation induction with intrauterine insemination in patients with endometriosis. Human Reproduction 1996; 11: 398-402.	1
Kinzer DR, Barrett CB, Powers RD, Kinzer DR, Barrett CB and Powers RD. Prognosis for clinical pregnancy and delivery after total fertilization failure during conventional in vitro fertilization or intracytoplasmic sperm injection. Fertility & Sterility 2008; 90: 284-288.	1
Kirby CA, Flaherty SP, Godfrey BM, Warnes GM and Matthews CD. A prospective trial of intrauterine insemination of motile spermatozoa versus timed intercourse. Fertility & Sterility 1991; 56: 102-107.	3
Kleinstein J. Efficacy and tolerability of vaginal progesterone capsules (Utrogest (TM) 200) compared with progesterone gel (Crinone (TM) 8%) for luteal phase support during assisted reproduction. Fertility and Sterility 2005; 83: 1641-1649.	1

Manuscript	Reason*
Kling C, Schmutzler A, Wilke G, Hedderich J, Kabelitz D, Kling C, Schmutzler A, Wilke G and Kabelitz D. Two-year outcome after recurrent implantation failure: prognostic factors and additional interventions. Archives of Gynecology & Obstetrics 2008; 278: 135-142.	2
Kling CM-Z. Effect of allogeneic leukocyte immunization on consecutive IVF/ICSI-treatment for failure in the in-vitro-fertilization program. Geburtshilfe und Frauenheilkunde 2002; 62: 661-667.	2
Kling CS. IVF prognosis after recurrent implantation failure: Experience of German centers. Geburtshilfe und Frauenheilkunde 2008; 68: 505-511.	2
Kling CW. Outcome two years after recurrent IVF implantation failure. Geburtshilfe und Frauenheilkunde 2007; 67: 1002-1008.	2
Knaggs P, Birch D, Drury S, Morgan M, Kumari S, Sriskandakumar R and Avery S. Full compliance with the EU tissue directive air quality standards does not compromise IVF outcome. Human Reproduction 2007; 22: 420.	1
Kuivasaari-Pirinen PH. Cumulative baby take-home rate among women with PCOS treated by IVF. Gynecological Endocrinology 2010; 26: 582-589.	2
Kupka MSF. Prognostic factors of assisted reproduction. Analyses based on results from the German IVF Registry. Gynakologe 2004; 37: 686-695.	1
Land JA, Courtar DA and Evers JL. Patient dropout in an assisted reproductive technology program: implications for pregnancy rates. Fertility & Sterility 1997; 68: 278-281.	2
Lashen H, Afnan M and Kennefik A. Early resort to ovarian stimulation improves the cost-effectiveness of a donor insemination programme. Human Reproduction 1999; 14: 1983-1988.	1
Lashen H, Ledger W, Lopez-Bernal A and Barlow D. Poor responders to ovulation induction: is proceeding to in-vitro fertilization worthwhile? Human Reproduction 1999; 14: 964-969.	1
Le SQK. When less is more: Simplified protocols for in vitro fertilization. Assisted Reproduction Reviews 1996; 6: 67-71.	1
Lindheim SR, Barad DH, Zinger M, Witt B, Amin H, Cohen B, Fisch H and Barg P. Abnormal sperm morphology is highly predictive of pregnancy outcome during controlled ovarian hyperstimulation and intrauterine insemination. Journal of Assisted Reproduction & Genetics 1996; 13: 569-572.	1
Lintsen AM, Verhaak CM, Eijkemans MJ, Smeenk JM, Braat DD, Lintsen AME, Eijkemans MJC, Smeenk JMJ and Braat DDM. Anxiety and depression have no influence on the cancellation and pregnancy rates of a first IVF or ICSI treatment. Human Reproduction 2009; 24: 1092-1098.	1
Lipitz S, Rabinovici J, Ben-Shlomo I, Bider D, Ben-Rafael Z, Mashiach S and Dor J. Complete failure of fertilization in couples with unexplained infertility: implications for subsequent in vitro fertilization cycles. Fertility & Sterility 1993; 59: 348-352.	2
Lipitz S, Rabinovici J, Goldenberg M, Bider D, Dor J and Mashiach S. Complete failure of fertilization in couples with mechanical infertility: implications for subsequent in vitro fertilization cycles. Fertility & Sterility 1994; 61: 863-866.	2
Liu DY, Bourne H and Baker HW. High fertilization and pregnancy rates after intracytoplasmic sperm injection in patients with disordered zona pellucida-induced acrosome reaction. Fertility & Sterility 1997; 67: 955-958.	3
Mahadevan MM, Leeton JF, Trounson AO and Wood C. Successful use of in vitro fertilization for patients with persisting low-quality semen. Annals of the New York Academy of Sciences 1985; 442: 293-300.	1
Mahmud G, Bernal AL, Yudkin P, Ledger W and Barlow DH. A Controlled Assessment of the In-Vitro Fertilization Performance of British Women of Indian Origin Compared with White Women. Fertility and Sterility 1995; 64: 103-106.	2
Malcolm CE and Cumming DC. Should we try to understand the high rate of dropout from fertility treatment? Fertility and Sterility 2004; 81: 278-278.	6
Mao K and Wood C. Barriers to treatment of infertility by in-vitro fertilization and embryo transfer. Medical Journal of Australia 1984; 140: 532-533.	2

Manuscript	Reason*
Marcus D, Marcus A, Johnson A and Marcus S. Infertility treatment: when is it time to give up? An Internet-based survey. Human Fertility 2011; 14: 29-34.	2
Marshall DC, Surrey M, VanVoorhis B, Kenigsberg D, Check JH, McShane P, Eisermann J, Scheiber MD, Westphal LM and Keye WR. A randomized, comparative, 3-arm, parallel group, open-label, multi-center study of the efficacy and safety of Bravelle (TM) (purified human FSH) and Repronex (R) when mixed in the same syringe and administered subcutaneously in continuous or sequential dose ratios to patients (34-40 years) undergoing in-vitro fertilization: interim data. Fertility and Sterility 2002; 77: 11.	1
Martin JS, Nisker JA, Parker JI, Kaplan B, Tummon IS and Yuzpe AA. The Pregnancy Rates of Cohorts of Idiopathic Infertility Couples Gives Insights Into the Underlying Mechanism of Infertility. Fertility and Sterility 1995; 64: 98-102.	1
Matsubayashi H, Hosaka T, Makino TEMA and Matsubayashi Hh. Impact of psychological distress in infertile Japanese women. [References]. Columbus, Alexandra M [Ed]: Nova.	1
McDowell S and Murray A. Barriers to continuing in vitro fertilisation--why do patients exit fertility treatment? Australian & New Zealand Journal of Obstetrics & Gynaecology 2011; 51: 84-90.	2
Moini A, Salehizadeh S, Moosavi F, Kiani K and Khafri S. Discontinuation Decision in Assisted Reproductive Techniques. International Journal of Fertility & Sterility 2009; 2: 173-178.	2
Moomjy M, Sills ES, Rosenwaks Z and Palermo GD. Implications of complete fertilization failure after intracytoplasmic sperm injection for subsequent fertilization and reproductive outcome. Human Reproduction 1998; 13: 2212-2216.	2
Nap AW, Van Golde RJT, Tuerlings JHAM, De Sutter P, Pieters MHEC, Giltay JC, Kastrop PMM, Braat DDM and Kremer JAM. Reproductive decisions of men with microdeletions of the Y chromosome: the role of genetic counselling. Human Reproduction 1999; 14: 2166-2169.	4
Nardo FDA. Results of intrauterine insemination following induction of multiple follicle growth (MFG). Revue Francaise de Gynecologie et d'Obstetrique 1994; 89: 382-386.	2
Nawroth FS. Possible simplification and rationalisation of in-vitro fertilisation (IVF) - Developments and actual situation. Geburtshilfe und Frauenheilkunde 1999; 59: 199-208.	1
Oktay K, Cil AP, Oktem O and Bang H. Continuous combined letrozole-FSH stimulation requires less FSH with similar outcomes compared to standard ovarian stimulation regimens for IVF. Fertility and Sterility 2005; 84: S94-S94.	1
Olivius C, Friden B, Borg G and Bergh C. Psychological aspects of discontinuation of in vitro fertilization treatment. Fertility and Sterility 2004; 81: 276-276.	6
Olivius C, Friden B, Borg G and Bergh C. Why do couples discontinue in vitro fertilization treatment? A cohort study. Fertility and Sterility 2004; 81: 258-261.	3
Olivius K, Friden B, Lundin K, Bergh C, Olivius K, Friden B, Lundin K and Bergh C. Cumulative probability of live birth after three in vitro fertilization/intracytoplasmic sperm injection cycles. Fertility & Sterility 2002; 77: 505-510.	3
Omland AK, Abyholm T, Fedorcs, x00E, k P, Ertzeid G, Oldereid NB, Bjercke S, Tanbo T, Omland AK, et al. Pregnancy outcome after IVF and ICSI in unexplained, endometriosis-associated and tubal factor infertility. Human Reproduction 2005; 20: 722-727.	1
Osmanagaoglu K, Collins J, Kolibianakis E, Tournaye H, Camus M, Van SA, Devroey P, Osmanagaoglu K, Collins J, Kolibianakis E, et al. Spontaneous pregnancies in couples who discontinued intracytoplasmic sperm injection treatment: a 5-year follow-up study. Fertility & Sterility 2002; 78: 550-556.	1
Osmanagaoglu K, Tournaye H, Kolibianakis E, Camus M, Van Steirteghem A and Devroey P. Spontaneous live births in couples discontinuing ICSI treatment: a follow-up of five years. Fertility and Sterility 2001; 76: 131.	1

Manuscript	Reason*
Owens DJ, Edelmann RE and Humphrey ME. Male infertility and donor insemination: couples' decisions, reactions and counselling needs. Human Reproduction 1993; 8: 880-885.	1
Ozgur K, Isikoglu M and Seleker M. Continuation of gonadotropin releasing hormone agonist during the luteal phase in in vitro fertilization patients: Is it beneficial? Fertility and Sterility 2002; 78: O137.	1
Panagopoulou E, Montgomery A, Tarlatzis B, Panagopoulou E, Montgomery A and Tarlatzis B. Experimental emotional disclosure in women undergoing infertility treatment: Are drop outs better off? Social Science & Medicine 2009; 69: 678-681.	1
Paulson RJ and Sauer MV. Counseling the Infertile Couple - When Enough Is Enough. Obstetrics and gynecology 1991; 78: 462-464.	1
Peddie VL. A qualitative study of women's decision-making at the end of IVF treatment. Human Reproduction 2005; 20: 1944-1951.	5
Peddie VL, Van TE, Bhattacharya S, Peddie VL, Van Teijlingen E and Bhattacharya S. Ending in-vitro fertilization: women's perception's of decision making. Human Fertility 2004; 7: 31-37.	1
Penzias AS. When and why does the dream die? Or does it? Fertility and Sterility 2004; 81: 274-275.	6
Peters K. Failures of reproduction: problematising 'success' in assisted reproductive technology. Nursing Inquiry 2007 June. 14.	1
Plasencia Acevedo WG. Analysis of 2304 intrauterine artificial insemination cycles. Revista Iberoamericana de Fertilidad y Reproduccion Humana 2004; 21: 217-224.	1
Qureshi NS, Walker SE, Pike DJ and Murray A. Transport in vitro fertilisation: three years experience at a district general hospital. Journal of Obstetrics & Gynaecology 1997; 17: 457-460.	1
Rajkhowa M, McConnell A and Thomas GE. Reasons for discontinuation of IVF treatment: a questionnaire study. Human Reproduction 2006; 21: 358-363.	3
Rauprich O, Berns E and Vollmann J. Information provision and decision-making in assisted reproduction treatment: Results from a survey in Germany, 2011. Human Reproduction. 26 (9) (pp 2382-2391), 2011.	1
Redmond MLH. Evaluating practice at an Irish tertiary level fertility clinic 1995/98. Irish medical journal 2000; 93: 112-114.	2
Repping S, van Weert JM, Mol BWJ, de Vries JWA and van der Veen F. Use of the total motile sperm count to predict total fertilization failure in in vitro fertilization. Fertility and Sterility 2002; 78: 22-28.	1
Rojanasakul A, Suchartwatnachai C, Choktanasiri W, Wongkularb A, Hansinlawat P and Chinsomboon S. Two years' experience of intrauterine insemination for the treatment of infertility. Journal of the Medical Association of Thailand 1993; 76: 415-423.	2
Rojas FJ. Effects of ovulation induction with gonadotrophins on the ovary and uterus and their implications for assisted reproduction. Human Reproduction 1995; 10: 2219-2224.	1
Rossin-Amar B. Analysis of the cancellations and temporary suspensions: The FIVNAT data. Journal de Gynecologie Obstetrique et Biologie de la Reproduction 2005; 34: 5S14-15S17.	2
Saleh A, Tan SL, Biljan MM and Tulandi T. A randomized study of the effect of 10 minutes of bed rest after intrauterine insemination. Fertility & Sterility 2000; 74: 509-511.	1
Salvatore PG. Psychopathology, personality, and marital relationship in patients undergoing in vitro fertilization procedures. Fertility and Sterility 2001; 75: 1119-1125.	1
Schachter M, Friedler S, Raziel A, Strassburger D, Bern O and Ron-el R. Improvement of IVF outcome in poor responders by discontinuation of GnRH analogue during the gonadotropin stimulation phase - A function of improved embryo quality. Journal of Assisted Reproduction and Genetics 2001; 18: 197-204.	1
Schoolcraft W, Miller C, Check J, Foulk R, Kolb B and Wakim A. Efficacy of a novel form of vaginal progesterone on continuing pregnancy rates in women undergoing IVF with elevated BMI and advanced age. Fertility and Sterility 2007; 87: P-33.	1

Manuscript	Reason*
Schroder AKK. Cumulative pregnancy rates and drop-out rates in a German IVF programme: 4102 cycles in 2130 patients. Reproductive BioMedicine Online 2004; 8: 600-606.	3
Schroder AKK. Cumulative pregnancy rates and drop-out rates of patients >= 40 years: 394 Cycles in 151 patients. Geburtshilfe und Frauenheilkunde 2004; 64: 723-729.	2
Sharara FI. Effects of hydrosalpinx on IVF outcome: the search goes on. Human Reproduction 1997; 12: 2853-2854.	1
Slade P, Emery J and Lieberman BA. A prospective, longitudinal study of emotions and relationships in in-vitro fertilization treatment. Human Reproduction 1997; 12: 183-190.	2
Smeenk JM, Verhaak CM, Braat DD, Smeenk JMJ, Verhaak CM and Braat DDM. Psychological interference in in vitro fertilization treatment. Fertility & Sterility 2004; 81: 277.	6
Soullier N, Bouyer J, Pouly JL, Guibert J, de La RE and de La Rochebrochard E. Estimating the success of an in vitro fertilization programme using multiple imputation. Human Reproduction 2008; 23: 187-192.	3
Soullier N, Bouyer J, Pouly J-L, Guibert J and de la Rochebrochard E. Effect of the woman's age on discontinuation of IVF treatment. Reproductive BioMedicine Online 2011; 22: 496-500.	3
Speyer BE, Pizzey AR, Ranieri M, Joshi R, Delhanty JD, Serhal P and Delhanty JDA. Fall in implantation rates following ICSI with sperm with high DNA fragmentation. Human Reproduction 2010; 25: 1609-1618.	1
Stolwijk AM, Wetzels AM and Braat DD. Cumulative probability of achieving an ongoing pregnancy after in-vitro fertilization and intracytoplasmic sperm injection according to a woman's age, subfertility diagnosis and primary or secondary subfertility. Human Reproduction 2000; 15: 203-209.	2
Strauss B, Hepp U, Staeding G and Mettler L. Psychological characteristics of infertile couples: Can they predict pregnancy and treatment persistence? Journal of Community & Applied Social Psychology 1998; 8: 289-301.	2
Su TJ, Chen HF, Chen YC, Yang YS and Hung YT. Factors related to meaning of life in Taiwanese women treated with in vitro fertilization. Journal of the Formosan Medical Association 2006; 105: 404-413.	2
Su TJ, Tzeng YL and Kuo PC. The anxiety of Taiwanese women with or without continuity treatment after previous in vitro fertilisation failure. Journal of Clinical Nursing 2011; 20: 2217-2223.	2
Takefman JE. Ending treatment. [References]. Covington, Sharon N [Ed]; Burns, Linda Hammer [Ed]: A-439.	6
Tanahatoe SJ, Lambalk CB, Hompes PG and Hompes PGA. The role of laparoscopy in intrauterine insemination: a prospective randomized reallocation study. Human Reproduction 2005; 20: 3225-3230.	2
Tarlatzis BC and Grimbizis G. Future use of clomiphene in ovarian stimulation. Will clomiphene persist in the 21st century? Human Reproduction 1998; 13: 2356-2358.	1
Valkenburg MH, Evers JL and Dumoulin JC. Pregnancies during and after homologous intrauterine insemination cycles. Gynecologic & Obstetric Investigation 1990; 29: 250-254.	1
Van Balen F and Verdurmen J. Medical anxiety and the choice for treatment: The development of an instrument to measure fear of treatment. Psychology & Health.14.	1
van Balen F, Verdurmen J and Ketting E. Choices and motivations of infertile couples. Patient Education and Counseling.31.	1
Van den Broeck U, Holvoet L, Enzlin P, Bakelants E, Demyttenaere K and D'Hooghe T. Reasons for Dropout in Infertility Treatment. Gynecologic and Obstetric Investigation 2009; 68: 58-64.	2
van Weert JM, van den BJ, van der Steeg JW, van dV, Flierman PA, Mol BW, Steures P, van Weert JM, van den Broek J, van der Steeg JW, et al. Patients' preferences for intrauterine insemination or in-vitro fertilization. Reproductive BioMedicine Online 2007; 15: 422-427.	1
VanderLaan BKV. Cost considerations with infertility therapy: Outcome and cost comparison between health maintenance organization and preferred provider organization care based on physician and facility cost. Human Reproduction 1998; 13: 1200-1205.	2
Vernaeve V, Festre V, Baetens P, Devroey P, Van Steirteghem A and Tournaye H. Reproductive decisions by couples undergoing artificial insemination with donor sperm for severe male infertility: implications for medical counselling. International Journal of Andrology 2005; 28: 22-26.	2

Manuscript	Reason*
Virro MRS. Pregnancy outcome in 242 conceptions after artificial insemination with donor sperm and effects of maternal age on the prognosis for successful pregnancy. American Journal of Obstetrics and Gynecology 1984; 148: 518-524.	2
Vlaisavljevic V, Meden-Vrtovec H, Lewandowski P, Radwan M, Langerova A, Vicena M, Valky J, Herman M, Usoniene A and Treijs G. An observational study of assisted reproductive technology outcomes in new European Union member states: an overview of protocols used for ovarian stimulation. Current Medical Research and Opinion 2010; 26: 819-825.	1
Witsenburg C, Dieben S, Van der Westerlaken L, Verburg H and Naaktgeboren N. Cumulative live birth rates in cohorts of patients treated with in vitro fertilization or intracytoplasmic sperm injection. Fertility and Sterility 2005; 84: 99-107.	2
Wurfel WK. Intracytoplasmic sperm injection (ICSI) with spermatozoa from the epididymidis (MESA) and the testis (TESE): A retrospective analysis of more than 500 treatment cycles. Geburtshilfe und Frauenheilkunde 1998; 58: 426-432.	1
Yamamoto SU. Poor pregnancy outcome following assisted reproductive technology among women operated on for bilateral endometriomas. Reproductive Medicine and Biology 2010; 9: 43-49.	1
Youssef GM. Progesterone supplementation in clomiphene citrate treated anovulatory patients with menstrual irregularities: A randomized controlled trial. Middle East Fertility Society Journal 2000; 5: 209-212.	2

* Reasons for exclusion classified as: 1- No data on discontinuation (n = 107); 2 - Data on discontinuation but not on outcomes investigated (n = 57); 3 - Data on discontinuation but insufficient or inconsistent (n = 11); 4 - Data on discontinuation but decision due to other matters (n = 1); 5 - Qualitative paper (n = 2); 6 - Review, letter to editor, etc. (n = 11).

Supplementary material – Table 3. Quality assessment of studies using criteria adapted from Newcastle-Ottawa quality assessment scale (scoring details)

Study	Quality criterion				Overall quality rating (0-6)
	Representative population [§] (1)	Ascertainment of treatment trajectory [†] (3)	Comparability [‡] (2)	Follow up [δ] (1)	
Brandes et al. 2009	* Study reports on all patients during the data collection period	* Reports on discontinuation before recommended cycles, controls for pregnancy and discontinuation due to poor prognosis * Follow up of 12 months, controls for going to other clinics * Medical record	* Sample with no previous ART experience, data collection < 5 years * Insurance coverage for all patients, women mean age < 40 years, conventional IVF/ICSI for all	* completion rate = 96.8%	7 (High)
Danesh-Meyer et al. 1993	* Study reports on all patients during the data collection period	- Does not report on treatment coverage, does not identify patients who discontinued due to poor prognosis - Follow up is not reported - No description of how discontinuation was ascertained	*All participant were at the same treatment stage, data collection < 5 years * Controls for age	* completion rate = 87.3%	4 (Average)
De Vries et al. 1999	* Study reports on all patients during the data collection period	- Does not identify patients who discontinued due to poor prognosis * Follow up of 12 months * Medical record	* Sample with no previous ART experience, data collection < 5 years * Women mean age < 40, conventional IVF/ICSI for all	* completion rate = 91.7%	6 (High)
Domar et al. 2010	- Only 37% response rate and N < 300	* Reports on discontinuation before recommended cycles, controls for pregnancy and discontinuation due to poor prognosis * Follow up of 12 months and controls for going to other clinics * Medical record	* Sample with no previous ART experience, data collection < 5 years * Insurance coverage for all patients, all women < 40	NA	5 (High)
Eisenberg et al. 2010	* Response rate = 54% but N > 300 and no obvious selection bias	- Does not report on treatment coverage * Follow up of 18 months - Self record	* All patients presenting for initial consultation, data collection < 5 years * Controls for age	* completion rate = 89%	5 (Average)
Goldfarb et al. 1997	- Response rate = 51.9%, N < 300	- Does not report on treatment coverage * Follow up of 2 years and controls for going to other clinics * Medical record	* All patients starting ART, data collection < 5 years * Controls for age and all patients received the same treatment protocol	NA	4 (Average)
Guerif et al. 2002	* Study reports on all patients during the data collection period	* Reports on discontinuation before recommended cycles, controls for pregnancy and reports on discontinuation due to poor prognosis (although not per cycle) * Follow up of 12 months * Medical record	- Some patients went directly to IVF-D while others did several IUI-D before, data collection > 5 yrs * Insurance coverage for all patients, women mean age < 40 years, IVF with donor sperm for all	* all cases accounted for	6 (High)
Guerif et al. 2003	* Study reports on all patients during the data collection period	* Reports on discontinuation before recommended cycles, controls for pregnancy and discontinuation due to poor prognosis * Follow up of 12 months * Medical record	- Data collection > 5 years *Insurance coverage for all patients, women mean age < 40 years, all patients receive the same treatment protocol	* completion rate = 94.6%	6 (High)

Study	Quality criterion				Overall quality rating (0-6)
	Representative population [§] **(1)**	**Ascertainment of treatment trajectory** [†] **(3)**	**Comparability** [‡] **(2)**	**Follow up** [δ] **(1)**	
Malcom & Cumming 2004	* Study reports on all patients during the data collection period	- Does not report on treatment coverage * Folow up of 2 years and 8 months and controls for going to other clinics - Self report	* All patients at the investigation phase, data collection < 5 years * None had insurance coverage, controls for age	* completion rate = 93.8%	5 (Average)
Meijer et al. 1980	* Study reports on all patients during the data collection period	- Does not report on treatment coverage - Follow up not reported * Medical record	- data collection > 5 years	* all cases accounted for	3 (Average)
Meynol, Silva & Gillet, 2007	- Response rate = 54.8%, N < 300	- Does not report on treatment coverage * Controls for going to other clinics - Self report	- data collection > 5 years - Does not report on access to treatment, prognosis indicators, type of treatment	NA	1 (Low)
Pearson et al. 2009	* Study reports on all patients during the data collection period	- Does not identify patients who discontinued due to poor prognosis - Does not report of follow-up period and does not control for going to other clinics * Medical record	- All patients starting ART but data collection period > 5 years * Women mean age < 40 years, frozen embryo transfers not considered	* completion rate = 98.8%	4 (Average)
Pelinck et al. 2007	* Study reports on all patients during the data collection period	* Reports on discontinuation before recommended cycles, controls for pregnancy and discontinuation due to poor prognosis - Does not report of follow-up period and does not control for going to other clinics * Medical record	- Patients with different previous ART experience * Insurance coverage for all patients, women mean age < 40 years, modified natural IVF[a] for all, frozen embryo transfers not considered	* All cases accounted for	5 (Average)
Roest et al. 1998	* Study reports on all patients during the data collection period	- Does not identify patients who discontinued due to poor prognosis - Does not report of follow-up period and does not control for going to other clinics * Medical record	- No data on previous ART experience and data collection period > 5 years * Insurance coverage for all patients, transport IVF/ICSI[b] for all patients	* All cases accounted for	4 (Average)
Rufat et al. 1994	* Study reports on all patients during the data collection period	- Does not identify patients who discontinued due to poor prognosis * Follow up of 3 to 5 years * Medical record	* First ART treatment for all and data collection < 5 years * Women mean age < 38	* All cases accounted for	6 (High)
Schover et al. 1992 (and 1994)	* Study reports on all patients during the data collection period	- Treatment is not covered * Follow up of * Medical record	* All patients at the same treatment phase, data collection < 5 years * Controls for age and same treatment protocol for all	* completion rate = 48%	5 (Average)
Sharma et al. 2002	* Study reports on all patients during the data collection period	- Does not identify patients who discontinued due to poor prognosis - Does not report of follow-up period and does not control for going to other clinics * Medical record	- No data on previous ART experience * IVF excluding ICSI for all patients	* All cases accounted for	4 (Average)
Smeenk et al. 2004	* Consecutive recruitment of participants, response rate >86%	* Reports on discontinuation before recommended cycles, controls for pregnancy and discontinuation due to poor prognosis * Follow up of 12 months * Medical record	* First ART treatment for all and data collection < 5 years * Insurance coverage for all patients, women mean age < 40 years, conventional IVF/ICSI for all patients, frozen embryo transfers not considered	- completion rate = 37%	6 (High)

Study	Quality criterion				Overall quality rating (0-6)
	Representative population [ꞩ] **(1)**	**Ascertainment of treatment trajectory** [†] **(3)**	**Comparability** [‡] **(2)**	**Follow up** [δ] **(1)**	
Steures et al. 2007	* Study reports on all patients during the data collection period	- Does not identify patients who discontinued due to poor prognosis - Follow-up not reported and does not control for going to other clinics * Medical records	- data collection > 5 years * Insurance coverage for all patients, same treatment protocol for all	* All cases accounted for	4 (Average)
Van Dongen et al. 2010	* Study reports on all patients during the data collection period	- Does not report on treatment coverage * Follow up of 2 years *Medical records	* All patients at the same treatment phase, data collection < 5 years * Controls for age and all waiting for IVF/ICSI	* completion rate = 98,8%	6 (High)
Verberg et al. 2008	* Study reports on all patients during the data collection period	* Reports on discontinuation before recommended cycles, controls for pregnancy and discontinuation due to poor prognosis - Follow up 6 months * Medical records	* Some couples had ART experience but was controlled in analysis, data collection period < 5 years * Insurance coverage for all patients, controls for age,	* All cases accounted for	6 (High)
Verhagen et al. 2008	* Study reports on all patients during the data collection period	* Reports on discontinuation before recommended cycles, controls for pregnancy and discontinuation due to poor prognosis - Does not report of follow-up period and does not control for going to other clinics * Medical record	* First ART treatment for all and data collection < 5 years * Conventional IVF/ICSI for all patients, frozen embryo transfers not considered, frozen embryo transfers not considered	* All cases accounted for	6 (High)
TOTAL	**13.6% Low (0)** **86.4% High (1)**	**40.9% Low (0-1)** **36.4% Average (2)** **22.7% High (3)**	**9% Low (0)** **31.9% Average (1)** **59.1% High (2)**	**10% Low (0)** **90% High (1)**	**4.5% Low** **50% Average** **45.5% High**

Note: IVF = In vitro fertilization, ICSI = Intracytoplasmatic sperm injection, IVF-D = In vitro fertilization with donor sperm, IUI-D = Intrauterine insemination with donor sperm, * = 1 point awarded, - = no point awarded

[ꞩ] The representativeness criterion was met when more than 80% of eligible patients were invited and more than 80% agreed to participate, or when the study reported on all consecutive series of patients over a defined period of time, or when sample size was more than 300 (1 point)

[†] The ascertainment of treatment trajectory criterion was met if the study provided enough data to ascertain that withdrawal from treatment was premature (before three cycles completed and not pregnant and not due to poor prognosis; 1 point), that withdrawal was either permanent (at least 12 months period since last treatment cycle or permanence sufficiently justified by authors) or not only from the target clinic (patients did not go to other clinics) (1 point), and that withdrawal was ascertained from secure records (i.e., medical records, 1 point).

[‡] The comparability criterion was met if all participants were at the same treatment phase and data collection period was less than five years (1 point); and sample was homogeneous regarding access to treatment (i.e. insurance coverage or number of subsidized cycles was described) or poor prognosis factors (i.e. mean age for all sample <40 or no statistical significant difference in age between groups) or type of treatment (all patients received the same treatment protocol), or frozen embryo transfer cycles were not considered (1 point).

[δ] The follow-up criterion (only applicable for prospective studies) was met if all cases were accounted for or completion rate (number of patients with outcome at follow-up divided by the number of patients that initiated) was more than 80% or description of patients lost to follow-up showed lack of bias (1 point)

Prospective studies were assessed based on the four criteria described and quality ratings were grouped into low (0-2), average (3-5) and high (6-7) quality studies.

Cross sectional studies were assessed based on the first three criteria described and quality ratings were grouped into low (0-2), average (3-4) and high (5-6) quality studies.

Supplemental material – Table 4. Categories of reasons defined

A	Psychological burden of treatments
B	Physical burden of treatments
C	Psychological and physical burden of treatment
D	Clinic related reasons
E	Organizational problems
F	Relational problems
G	Marital or personal problems
H	Rejection of treatment
I	No faith in treatment success
J	Perception of poor prognosis
K	Logistics/practical reasons
L.	Personal reasons
M.	Adoption
N.	Other parenting options
O.	Abandonment of child wish
P.	Postponement of treatment
Q.	Postponement of treatment or unknown
R.	Doctor censuring
S.	Financial issues
T.	Health problems
U.	Other medical treatment
V.	Went to other clinics
W.	Other / unknown reasons / not reported
X.	Non-classifiable

Supplemental material – Table 5. Classification and number of selections per treatment stage of reasons presented in studies

Reasons descriptors – Brandes et al. 2009	Reasons' category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
emotional distress	A	12	25			28
relational problems	F	29	12			5
rejected IVF treatment	H	12	13			0
reject treatment in general	H	49	6			0
no faith in treatment,	I	4	1			4
age (women)	J	4	4			0
no potential treatment	R	10	0			0
poor prognosis (doctor's refusal)	R	0	6			19
financial	S	2	1			0
health problems (one of the partners)	T	11	0			1
unknown	W	11	7			0
Reasons descriptor – Domar et al. 2010	Meta-category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
Too anxious or depressed to continue	A					3
I could not stand all the injections	B					0
I could not stand side effects of medication	B					1
Infertility taking too much of a toll on our relationship	F					3
I was getting nervous about possible long-term effects of treatment	H					0
I had already given IVF my best chance	I					1
it was too difficult to get to IVF centre so often,	K					1
moved out of state	K					2
decided to pursue adoption or third-party conception,	M					2
needing to take a break from treatment,	P					7
advised by their physician to stop,	R					2
lost insurance coverage,	S					4
Other (subjects listed cost of medication and donor sperm)	S					0
changed IVF centers,	V					11
gave no reason,	W					4
Reasons descriptor – Danesh-Meyer et al. 1993	Meta-category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
separated	F		3			
moved to another district	K		38			
identifiable social reasons	L		2			
adopted	M		12			
partner deceased	T		0			
patient deceased	T		1			
gave no reason	W		2			
lost to follow-up	W		4			
decided to stop treatment	X		13			
medical reasons	X		4			
Reasons descriptor – Eisenberg et al. 2010	Meta-	Number of selections				

	category	Initiate	First	ART Start	ART Failed	ART Typical
emotional stress	A	11				
medical futility	J	14				
personal life circumstances (i.e. moving, death in family, return to school)	L	21				
financial concerns	S	32				
Reasons descriptor – Goldfarb et al. 1997	Meta-category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
emotional distress	A				15	
physical discomfort	B				3	
financial concern	S				20	
went to different IVF program	U				2	
Reasons descriptor – Guerif et al. 2003	Meta-category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
divorce	F		1			
move	K		1			
adoption	M		4			
decision to postpone further treatment	P		31			
Active censuring (medical reasons)	R		10			
loss to follow-up	W		9			
Reasons descriptor – Malcom & Cumming 2004	Meta-category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
emotional distress	A		4			
side effects from treatment	B		2			
clinic reason	D		8			
separated/divorced	F		8			
not interested in treatment	H		13			
not meant to be	I		7			
just gave up	I		2			
poor prognosis	J		28			
distance to clinic	K		2			
moved away	K		97			
partner away at present	K		2			
personal	L		17			
adoption	M		18			
pursuing alternative therapy	N		1			
trying on own	N		2			
change in priorities	O		7			
physician reason	R		9			
financial	S		13			
ART (IVF performed)	U		4			
ART (going to IVF)	U		4			
referred to other provider	V		3			
patients not contacted	W		34			
Reasons descriptor – Meynol et al. 2007	Meta-category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
stress	A				24	
poor tolerance to physical side of	B				9	

treatment						
retrieval to painful	B				15	
treatment too aggressive for partner	B				5	
insufficient or poorly formulated explanations about healthcare or fertility problem	D				10	
poor management of psychological aspects	D				15	
therapeutic programme difficult to integrate with work	E				20	
marital problems subsequent to start of treatment	F				9	
separation of couple	F				7	
fear of abnormal child	H				2	
adoption	M				4	
abandoned child wish	O				4	
partner abandoned child wish	O				3	
changed medical teams to other clinic (in other city or private care)	V				12	
need for using sperm donor	X				4	
Reasons descriptor – Meijer et al. 1980	Meta-category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
too much stress	A		1			
can’t stand it	A		2			
divorce	F		2			
too old	J		1			
adoption	M		8			
don’t want children anymore	O		1			
active censuring	R		29			
other treatment	U		2			
unknown	W		2			
Reasons descriptor – Pelinck et al. 2007	Meta-category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
psychological stress or physical burden	C					5
marital or personal problems	G					7
problem with semen quality	J					1
problem with the menstrual cycle	J					1
moved	K					1
problem with sperm donor	K					1
planned to adopt	M					3
financial problems	S					1
illness or operation needed	T					3
no specific reason	W					19
Reasons descriptor – Smeenk et al. 2004	Meta-category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
psychological reasons	A				10	17
fear of complications	H				9	13
postponement or unknown	Q				6	17
Active censuring	R				16	24
other medical treatment	U				1	7
Reasons descriptor – Verberg et al. 2008	Meta-	Number of selections				

	category	Initiate	First	ART Start	ART Failed	ART Typical
physical or psychological burden of treatment	C					18
relational problems / divorce	F					7
ethical objections to ICSI treatment after failed IVF treatment	H					6
adoption	M					5
active censuring (poor embryo quality)	R					5
active censuring (poor response/signs of ovarian aging)	R					4
other reasons	W					4
unknown	W					16
Reasons descriptor – Van Dongen et al. 2010	Meta-category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
psychological	A			7		
language problems	E			3		
relationship	F			10		
personal	L			6		
active censuring (medical)	R			12		
active censuring (failure to correct overweight status)	R			10		
active censuring (failure to correct underweight status)	R			1		
financial	S			2		
treatment elsewhere	V			2		
unknown	W			1		
Reasons descriptor – Verhagen et al. 2008	Meta-category	Number of selections				
		Initiate	First	ART Start	ART Failed	ART Typical
psychological burden	A					8
physical burden	B					4
both psychological and physical burden	C					18
relational problems	F					6
active censuring (poor response, poor fertilization, poor response with poor fertilization, overweight with BMI > 30 kg/m^2, hypertension or improved semen quality not requiring ICSI any more)	R					51
additional health problems	T					3
continuation of treatment elsewhere	V					6
unknown reasons	W					12

Supplemental material - Table 6. Reasons to discontinue from fertility treatment. Number of selections of each reason reported in the studies included in the systematic review, per decision-making stage

	INITIATE		FIRST					ART START	ART FAILED			ART TYPICAL					
	Brandes 2009	Eisenberg 2010	Brandes 2009	Danesh-Meyer 1993	Guerif 2003	Malcom 2004	Meijer 1989	Van Dongen 2010	Goaldfarb 1997	Meynol 1997	Smeekn 2004	Brandes 2009	Domar 2010	Pelinck 2007	Smeenk 2004	Verberg 2008	Verhagen 2008
Nr patients discontinued	144	55	75	79	56	285	48	54	28	46	42	57	41	42	78	65	108
Multiple reasons selection (Yes/No)	No	Yes	No	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No	No
Reasons																	
Treatment																	
Physical burden of treatment						2			3	29			1				4
Psychological burden of treatment	12	11	25			4	3	7	15	24	10	28	3		17		8
Physical and psychological burden of treatment														5		18	18
Clinic																	
Clinic related reasons						8				25							
Organizational problems								3		20							
Patient																	
Relational problems	29		12	3	1	8	2	10		16		5	3			7	6
Marital or personal problems														7			
Rejection of treatment	61		19			13				2	9	0	0		13	6	
No Faith in treatment success	4		1			9						4	1				
Poor prognosis	4	14	4			28	1					0		2			
Logistics/practical reasons				38	1	101							3	2			
Personal reasons		21		2		17		6									
Adoption				12	4	18	8			4			2	3		5	
Other parenting options						3											
Abandonment of childwish						7	1			7							
Postponement of treatment					31								7				
Postponement of treatment or unknown											6				17		
External constraints																	
Doctor censuring	10		6		10	9	29	23			16	19	2		24	9	51
Financial issues	2	32	1			13		2	20			0	4	1			
Health problems	11		0	1								1		3			3
Other medical treatment						8	2		2		1				7		
Non interpretable																	
Went to other clinics						3		2		12			11				6
Other /unknown /not reported	11		7	6	9	34	2	1				0	4	19		20	12
Non-classifiable				17						4							
TOTAL	**144**	**78**	**75**	**79**	**56**	**285**	**48**	**54**	**40**	**143**	**42**	**57**	**41**	**42**	**78**	**65**	**108**

Note. Blank cells mean that the corresponding reason category was not investigated for the corresponding treatment stage.

Table 7. Reasons to discontinue from fertility treatment per fertility treatment stage.

Reasons for discontinuation	INITIATE			FIRST			ART – START			ART - FAILED			ART – TYPICAL			**TOTAL**		
	k	**s**	**S**	**k**	**s**	**S**	**k**	**s**	**S**	**k**	**s**	**S**	**k**	**s**	**S**	**k**	**s**	**S**
Treatment																		
Physical burden of treatments				1	2	285				2	32	183	2	5	149	5	39	617
Psychological burden of treatments	2	23	222	3	32	408	1	7	54	3	49	225	4	56	284	13	167	1193
Physical and psychological burden of treatment													3	41	215	3	41	215
Clinic																		
Clinic related reasons				1	8	285				1	25	143				2	33	428
Organizational problems							1	3	54	1	20	143				2	23	197
Patient																		
Relational problems	1	29	144	5	26	543	1	10	54	1	16	143	4	21	271	12	102	1155
Marital or personal problems													1	7	42	1	7	42
Rejection of treatment	1	61	144	2	32	360				2	11	185	4	19	241	9	123	930
No Faith in treatment success	1	4	144	2	10	360							2	5	98	5	19	602
Poor prognosis	2	18	222	3	33	408							2	2	99	7	53	729
Logistics/practical reasons				3	140	420							2	5	83	5	145	503
Personal reasons	1	21	78	2	19	364	1	6	54							4	46	496
Adoption				4	42	468				1	4	143	3	10	148	8	56	759
Other parenting options				1	3	285										1	3	285
Abandonment of childwish				2	8	333				1	7	143				3	15	476
Postponement of treatment				1	31	56							1	7	41	2	38	97
Postponement of treatment or unknown										1	6	42	1	17	78	2	23	120
External constraints																		
Doctor censuring	1	10	144	4	54	464	1	23	54	1	16	42	5	105	349	12	208	1053
Financial issues	2	34	222	2	14	360	1	2	54	1	20	40	3	5	140	9	75	816
Health problems	1	11	144	2	1	154							3	7	207	6	19	505
Other medical treatment				2	10	333				2	3	82	1	7	78	5	20	493
Non interpretable																		
Went to other clinics				1	3	285	1	2	54	1	12	143	2	17	149	5	34	631
Other /unknown /not reported	1	11	144	5	58	543	1	1	54				5	55	313	12	125	1054
Non-classifiable				1	17	79				1	4	143				2	21	222

Note: Blank cells mean that the corresponding reason category was not investigated for the corresponding treatment stage. For each reasons' category at each treatment stage, k = number of studies in the systematic review that investigated that category, s = number of selections of that category in all studies in the systematic review that investigated that category, S = total number of selections of all reasons' categories investigated in all studies in the systematic review that investigated that category.

Supplemental material - Table 8. Treatment correlates of discontinuation

	INITIATE	FIRST				ART FAILED	ART - FAILED & TYPICAL							ART ALL	
	Eisenberg 2010	Danesh-Meyer 1993	Guerif 2002	Guerif 2003	Steures 2007	Sharma 2002	De Vries 1999	Pearson 2009	Pelinck 2007	Roest 1998	Rufat 1994	Smeenk 2004	Verberg 2008	Verhagen 2008	■ Nr studies investigated predictor ■ Nr studies predictor associated higher discontinuation ■ Nr studies predictor associated lower discontinuation
Doctor censured patients excluded from analysis	No	No	Yes	Yes	No	No	No	No	No	No	No	Yes	No	No	
Correlates															
Infertility history															
Parity	NS							+					NS		3 / 1
Pregnancies prior IVF							+						NS		2 / 1
Previous fertility treatment			-	NS									NS		3 / 1
Infertility duration	NS	NS	NS	NS					NS			NS	NS	NS	8
Primary infertility							-		NS					NS	3 / 1
Male factor	NS	NS						NS					+	NS	5 / 1
Female factor	NS							NS					NS	NS	4
Unexplained/no diagnosis	NS							NS					NS	NS	4
Treatment															
Time to treatment				+									NS		2 / 1
Type of treatment														NS	1
Duration of treatment													NS		1
Nr visits to physician													NS		1
A priory estimated pregnancy rate					NS										1
Stimulation dosage						NS							+		2 / 1
Cancelled cycle													NS		1
Oocytes retrievals						-	NS	NS	-	NS			NS		6 / 2
Embryo fertilization.transfers. quality						-	NS	NS	-	NS	-		-		7 / 3
Use frozen embryos						NS							NS		2
Pregnancy lost/other comp								+[a]					NS		2 / 1

Parity: *Eisenberg 2010*: previous offspring (no/yes), NS; *Pearson 2009*: parity (no/yes), ART cycle 1: OR 1.58 (95%CI 1.18-2.10), p < .01, ART cycle 2: OR 1.66 (95%CI 1.16-2.37), p < .01; *Verberg 2008*: Previous childbirth (no/yes), HR 1.19 (95%CI 0.70 – 2.01), p = .50.
Pregnancies prior IVF: *De Vries 1999*: number previous pregnancies in medical history, p< .05; *Verberg 2008*: previous pregnancy (no/yes), HR 0.94 (95%CI 0.49 – 1.80), p = .90.
Previous fertility treatment: *Guerif 2002*: Nr cycles done (mean), ANOVA: discontinuers: 5.9±3.4, continuers: 8.0±3.1, p < .05; *Guerif 2003*: Nr cycles first course of patients returning to treatment after previously conceiving through donor insemination if first course of treatment (mean), ANOVA: NS; *Verberg 2008*: Previous fertility treatment (IUI or DI, no/yes), HR 0.78 (95%CI 0.48 – 1.27), p = .30.
Infertility duration: *Eisenberg 2010*: duration of infertility, NS; *Danesh-Meyer 1993*: infertility length, NS; *Guerif 2002*: duration of infertility (yrs), NS; *Guerif 2003*: duration of infertility (yrs), NS; *Pelinck 2007*: duration subfertility (months), p = .16; *Smeenk 2004*: duration of infertility (yrs), ART cycle 1: discontinuers: 4.1±2.5, continuers: 3.7±2.1, p > .05, ART cycle 2: discontinuers: 4.1±2.5, continuers: 3.7±2.1, p > .05; *Verberg 2008*: duration of infertility, HR 1.01 (95%CI 0.90 – 1.13), p = .8; *Verhagen 2008*: duration of subfertility (yrs), discontinuers: 3.5±2.4, continuers: 3.0±2.2, NS.
Primary infertility: *De Vries 1999*: primary infertility (no/yes), negative association with discontinuation, p < .05; *Pelinck 2007*: subfertility primary (%), χ^2: p = .85; *Verhagen 2008*: primary subfertility (n,%), discontinuers: 68,63%, continuers: 346,72.1%, NS.
Male factor: *Eisenberg 2010*: infertility diagnosis (female factor - ovarian, ovulatory, tubal, uterine; male factor; both; unknown), NS & perceived infertility diagnosis, NS; *Danesh-Meyer 1993*: indication for donor insemination (vasectomy, azoospermia, oligospermia), NS; *Pearson 2009*: diagnosis group, NS; *Verberg 2008*: category of infertility – male, HR 0.94 (95%CI 0.46 – 1.94), p = .90, severe male (treated with ICSI), HR 4.81 (95%CI 1.63 – 14.14), p = .004 ; *Verhagen 2008*: cause of subfertility - male factor (n, %), discontinuers: 55, 50.9%, continuers: 256, 53.3%, NS.
Female factor : *Eisenberg 2010*: infertility diagnosis (female factor - ovarian, ovulatory, tubal, uterine; male factor; both; unknown) & perceived infertility diagnosis, NS; *Pearson 2009*: diagnosis group, NS; *Verberg 2008*: category of infertility – endometriosis, HR 0.82 (95%CI 0.11 – 6.39), p = .80, immunological, HR 1.34 (95%CI 0.29 – 6.14), p = .70; *Verhagen 2008*: cause of subfertility - anovulation, (n, %), discontinuers: 1, 0.9%, continuers: 2, 0.4%, NS, endometriosis (n, %), discontinuers: 4, 3.7%, continuers: 17, 3.5%, NS; tubal factor (n, %), discontinuers: 22, 20.4%, continuers: 75, 15.6%, NS.
Unexplained/no diagnosis: *Eisenberg 2010*: infertility diagnosis (female factor - ovarian, ovulatory, tubal, uterine; male factor; both; unknown), NS & perceived infertility diagnosis, NS; *Pearson 2009*: diagnosis group, NS; *Verberg 2008*: category of infertility – unknown, HR 1.32 (95%CI 0.60 – 2.89), p = .5; *Verhagen 2008*: cause of subfertility – unexplained (n, %), discontinuers: 26, 24.1%, continuers: 130, 27.1%, NS.
Time to treatment: *Guerif 2003*: Time interval (months) between first and second treatment course in patients returning to treatment after previously conceiving through donor insemination in first course of treatment, ANOVA: discontinuers: 39±18 continuers: 30±12, p < .05; *Verberg 2008*: Delay before initiation of 1st treatment cycle, HR 1.00 (95%CI 1.00-1.01), p = .40, delay before the start of the cycle, OR 1.00 (95%CI 0.99 – 1.00), p = .21.
Type of treatment: *Verhagen 2008*: IVF versus ICSI (n, %), discontinuers: 51 vs 57, 47.2 vs. 52.8%, continuers: 219 vs. 261, 45.6 vs 54.4%, NS.
Duration of treatment: *Verberg 2008*: duration of treatment (days), OR 1.05 (95%CI 0.94 – 1.18), p = .40.
Nr visits to physician: *Verberg 2008*: number of visits to physician, OR 0.90 (95%CI 0.58–1.41), p = .70.
A priory estimated pregnancy rate: *Steures 2007*: A priori estimated change of an ongoing pregnancy after IUI, ANOVA: discontinuers: 7.8%±1.9%, continuers: 8.1%±2.0%, p = .15.
Stimulation dosage: *Sharma 2002*: total gonadotropin dose (ampoules), discontinuers: 42.91±25.18, continuers: 41.45±18.84, NS; *Verberg 2008*: treatment strategy (conventional, mild), HR 0.55 (95%CI 0.31-0.96), p =.034.
Cancelled cycle: *Verberg 2008*: cancelled cycle, OR 1.48 (95%CI 0.71 – 3.08), p = .3.

Oocytes retrievals: *Sharma 2002*: nr. of oocytes retrieved, discontinuers: 12.52±11.07, continuers: 12.99±8.11, p = .02; *De Vries 1999*: cancelation of ovum pick-up (n, %), χ^2: ART cycle 1: discontinuers: 12, 6%, continuers: 49, 9%, NS, ART cycle 2: discontinuers: 10, 9%, continuers: 16, 7%, NS & mean (±SD) nr of oocytes, ART cycle 1: discontinuers: 12.8±7.9, continuers: 11.8±6.8, NS, ART cycle 2: discontinuers: 12.1±8.0, continuers: 11.3±6.8, NS & oocytes < 4 (n, %), ART cycle 1: discontinuers: 18, 9%, continuers: 46, 9%, NS, ART cycle 2: discontinuers: 10, 10%, continuers: 22, 11%, NS; *Pearson 2009*: no oocyte retrieval (vs. failed embryo implantation), ART cycle 1: OR 1.13 (95%CI 0.77-1.66), p = .54, ART cycle 2: OR 0.65 (95%CI 0.40-1.05), p = .08; *Pelinck 2007*: oocyte retrievals performed (% / cycle), p < .05, oocyte retrievals successful (% / attempt), NS; *Roest 1998*: oocytes ≤ 2 (%), discontinuers: 11.4, continuers, 12.8, NS; *Verberg 2008*: ovarian response, OR 0.98 (0.93 – 1.04), p = .50.

Embryo fertilization, transfers & quality: *Sharma 2002*: patients with > 2 embryos (%),χ^2: discontinuers:52, continuers: 71, p < .0001 & fertilization rate (%), discontinuers: 46, continuers: 49, NS & cleavage rate (%),χ^2: discontinuers: 81, continuers: 84, NS; *De Vries 1999*: mean (±SD) fertilization rate in IVF, ART cycle 1: discontinuers: 55.2±33.5, continuers: 50.2±33.9, NS, ART cycle 2: discontinuers: 68.1±21.1, continuers: 58.2±32.0, NS & mean (±SD) fertilization rate in ICSI, ART cycle 1: discontinuers: 71.2±27.7, continuers: 50.2±33.9, NS, ART cycle 2: discontinuers: 74.1±25.8, continuers: 71.2±25.5, NS & embryo transfers < 2(%), ART cycle 1: discontinuers: 38, 21%, continuers: 90, 18%, NS, ART cycle 2: discontinuers: 13, 14%, continuers: 28, 14%, NS & mean (±SD) total quality score of embryo transferred, ART cycle 1: discontinuers: 7.4±3.0, continuers: 7.0±2.3, p > .05, ART cycle 2: discontinuers: 7.8±2.8, continuers: 7.5±2.4, NS; *Pearson 2009*: failed fertilization (vs. failed embryo implantation), ART cycle 1: OR 1.09 (95%CI 0.72-1.67), p = .68, ART cycle 2: OR 1.29 (95%CI 0.78-2.13), p = .33; *Pelinck 2007*: embryo transfers (% / cycle), p < .05 & fertilization (% / successful oocyte retrieval), p < .05; *Roest 1998*: number of embryo transferred < 2 (%), discontinuers: 37.3, continuers: 34.2, p > .05 & fertilization rate (%), discontinuers: 43, continuers: 45, p > .05; *Rufat 1994*: absence of embryo transfers, ART cycle 1: discontinuers: 34%, continuers: 26%, X2 = 54, p < .05, ART cycle 2: discontinuers: 33%, continuers: 24%, p < .04; *Verberg 2008*: availability of an embryo for transfer, OR 0.41 (95%CI 0.24 – 0.72), p = .002 & availability of a top-quality embryo for transfer, OR 0.64 (95%CI 0.37 – 1.09), p = .10.

Use frozen embryos: *Sharma 2002*: patients with frozen embryos (%), discontinuers: 26.2, continuers: 28.9, NS; *Verberg 2008*: cryo preserved embryo transfer cycle, OR 1.23 (0.58 – 2.60), p = .60.

Pregnancy lost / other complications: *Pearson 2009*: chemical pregnancy only (vs. failed embryo implantation), ART cycle 1: OR 1.51 (95%CI 1.04-2.17), p = .03, ART cycle 2: OR 1.09 (95%CI 0.67-1.76), p = .74 & clinical pregnancy loss (vs. failed embryo implantation), ART cycle 1: OR 1.88 (95%CI 1.22-2.90), p < .01, ART cycle 2: OR 0.95 (95%CI 0.52-1.72), p = .86; *Verberg 2008*: early pregnancy loss, OR 1.65 (95%CI 0.65 – 4.18), p = .30, complications, OR 0.93 (95%CI 0.27 – 3.14), p = .90.

[a] moderation effect of treatment cycle between pregnancy lost / other complications and discontinuation, chemical pregnancy only (vs. failed embryo implantation), ART cycle 1: OR 1.51 (95%CI 1.04-2.17), p = .03, ART cycle 2: OR 1.09 (95%CI 0.67-1.76), p = .74 & clinical pregnancy loss (vs. failed embryo implantation), ART cycle 1: OR 1.88 (95%CI 1.22-2.90), p < .01, ART cycle 2: OR 0.95 (95%CI 0.52-1.72), p = .86

Supplemental material - Table 9. Patient correlates of discontinuation

	INITIATE	FIRST				ART FAILED	ART - FAILED & TYPICAL							ART ALL	
	Eisenberg 2010	Danesh-Meyer 1993	Guerif 2002	Guerif 2003	Schover 1992	Sharma 2002	De Vries 1999	Pearson 2009	Pelinck 2007	Roest 1998	Rufat 1994	Smeenk 2004	Verberg 2008	Verhagen 2008	■ Nr studies investigated predictor ■ Nr studies predictor associated higher discontinuation ■ Nr studies predictor associated lower discontinuation
Doctor censured patients excluded from analysis	No	No	Yes	Yes	No	No	No	No	No	No	No	Yes	No	No	
Correlates															
Socio-demographic															
Age women	+	NS	NS	NS	+	+	+	NS	NS	NS	+	NS	NS	NS	14 / 5
Age men	NS				NS								NS		3
Education women	-				NS								NS		3 / 1
Education men	NS				NS										2
Financial issues	NS	NS			NS	NS									4
Distance of residence to clinic		NS													1
Ethnicity	NS														1
Religion	NS				NS										1
Psychosocial															
Anxiety women	NS											+[a]	NS[b]		3 / 1
Depression women	+											+[c]	NS		3 / 2
Distress women					NS										1
Distress men					NS										1
Relational/sexual adjustment woman					-							NS			2 / 1
Relational/sexual adjustment man					NS										1

Age women: *Eisenberg 2010*: age, OR 1.77 (95%CI 1.11-2.82), p = .02; *Danesh-Meyer 1993*: female age (yrs), NS; *Guerif 2002*: female age (yrs), NS; *Guerif 2003*: female age (yrs), NS; *Schover 1992*: women mean age, discontinuers: 34, continuers: 29, t(50) = -3.18, p < .003; *Sharma 2002*: age (yrs), discontinuers: 32.91±4.84, continuers: 32.31±4.04, p = .017; *De Vries 1999*: mean (±SD) age (yrs), ART cycle 1: discontinuers: 32.0±5.5, continuers: 31.0±4.3, p < .05, ART cycle 2: discontinuers: 32.0±4.7, continuers: 31.6±4.3, NS; *Pearson 2009*: woman's age at cycle start (yrs), 35-39 vs. 20-34,

ART cycle 1: OR 0.85 (95%CI 0.65-1.12), p = .25, ART cycle 2: OR 1.36 (95%CI 0.98-1.89), p = .07 & 40-49 vs. 20-34, ART cycle 1: OR 1.12 (95%CI 0.82-1.52), p = .49, ART cycle 2: 1.46 (1.01-2.11), p = .05; *Pelinck 2007*: female patient age (yrs), NS; *Roest 1998*: age (yrs), discontinuers: 32.4±4.6, continuers: 32.3±4.4, NS; *Rufat 1994*: ART cycle 1: discontinuers: 33.2±4.9, continuers: 32.5±4.6, t = 6.4, p < .001, ART cycle 2: discontinuers: 33.5±4.8, continuers: 32.9±4.4, t = 3.9, p < .05; *Smeenk 2004*: woman's age (yrs), ART cycle 1: discontinuers: 35.4±3.7, continuers: 33.8±3.8, NS, ART cycle 2: discontinuers: 33.9±4.0, continuers: 34.0±4.0, NS; *Verberg 2008*: age women, HR 0.94 (95%CI 0.87 – 1.01), p = .09; *Verhagen 2008*: age of female (yrs), discontinuers: 33.8±4.1, continuers: 32.9±3.6, NS.
Age men: *Eisenberg 2010*: age, NS; *Schover 1992*: age for husbands (yrs), NS; *Verberg 2008*: age men, HR 1.00 (95%CI 0.95 – 1.05), p = 1.0.
Education women: *Eisenberg 2010*: education (<= some college vs. >= college degree), OR 0.21 (95%CI 0.10-0.45), p < .001; *Schover 1992*: education (no college education, college education or above), NS; *Verberg 2008*: education level of women, p = .08.
Education men: *Eisenberg 2010*: education (<= some college vs. >= college degree), NS; *Schover 1992*: education (no college education, college education or above), NS.
Financial issues: *Eisenberg 2010*: Income (<= $100.000, $100.001 – $200.000, > $200.000), NS & insurance coverage (any health insurance, type of insurance, coverage for infertility services), NS; *Danesh-Meyer 1993*: socioeconomic status, NS; *Schover 1992*: family socioeconomic status (professional, white collar, blue collar), NS; *Sharma 2002*: funding source (self funded, other), discontinuers: 57%, 43%, continuers: 62%, 37%, p = .088.
Residence / distance from clinic: *Danesh-Meyer 1993*: country major regions, NS;
Ethnicity: *Eisenberg 2010*: race (white vs. other), NS.
Religion: *Eisenberg 2010*: religious affiliation, NS; *Schover 1992*: religion (Protestants, Evangelistic protestant, Catholic, Jewish, other), NS.
Anxiety women: *Eisenberg 2010*: pre treatment anxiety women (State-Trait Anxiety Inventory), NS; *Smeenk 2004*: pre treatment state anxiety (State and Trait Anxiety Inventory), ART cycle 1: discontinuers: 42.5±14.3, continuers: 36.3±10.0, p < .05, ART cycle 2: discontinuers: 38.0±12.4, continuers: 38.6±10.3, NS & pre treatment trait anxiety (State and Trait Anxiety Inventory), ART cycle 1: discontinuers: 39.6±10.0, continuers: 37.0±8.3, NS; *Verberg 2008*: pre-existing symptoms of anxiety (Hospital Anxiety and Depression Scale), HR 1.05 (95%CI 0.97–1.14), p = .21.
Depression women: *Eisenberg 2010*: pre treatment depression women (Center for Epidemological Studies Depression Scale), .5 SD increase, OR 1.23 (95%CI 1.01-1.51), p = .04; *Smeenk 2004*: pre-treatment depression score (Beck Depression Inventory), ART cycle 1: discontinuers: 9.5±8.7, continuers: 5.8±5.3, p < .05, ART cycle 2: discontinuers: 5.3±5.6, continuers: 6.9±6.0, NS; *Verberg 2008*: pre-existing symptoms of depression (Hospital Anxiety and Depression Scale), HR 1.06 (95%CI 0.95–1.17), p = .30;
Distress women: *Schover 1992*: pre treatment psychopathologic symptoms (Brief Symptom Inventory) & infertility stress (Stress and Infertility Questionnaire), NS.
Distress men: *Schover 1992*: pre treatment psychopathologic symptoms (Brief Symptom Inventory) & infertility stress (Stress and Infertility Questionnaire), NS.
Relational/sexual adjustment women: *Schover 1992*: pre treatment marital adjustment (Dyadic Adjustment Inventory), discontinuers more negative than continuers, t(49) = -2.72, p < .01; *Smeenk 2004*: relationship dissatisfaction (Maudsley Marital Questionnaire), ART cycle 1: discontinuers: 10.5±7.8, continuers: 9.8±7.3, NS, ART cycle 2: discontinuers: 8.3±6.2, continuers: 10.7±8.2, NS & sexual dissatisfaction (Maudsley Marital Questionnaire), ART cycle 1: discontinuers: 8.2±6.8, continuers: 7.7±6.1, NS, ART cycle 2: discontinuers: 5.1±5.8, continuers: 8.6±6.4, NS.
Relational/sexual adjustment men: *Schover 1992*: pre treatment marital adjustment (Dyadic Adjustment Inventory), NS.

[a] moderation effect of stimulation dosage on relationship between anxiety and discontinuation: 1.38 conventional, 1.16 mild (relative reduction in hazard 0.84 [0.72-0.99];
[b] moderation effect of treatment cycle (first, second) on relationship between pre treatment state anxiety and discontinuation, ART cycle 1: discontinuers: 42.5±14.3, continuers: 36.3±10.0, $p < .05$, ART cycle 2: discontinuers: 38.0±12.4, continuers: 38.6±10.3, $p > .05$
[c] moderation effect of treatment cycle (first, second) on relationship between pre treatment depression score and discontinuation, ART cycle 1: discontinuers: 9.5±8.7, continuers: 5.8±5.3, $p < .05$, ART cycle 2: discontinuers: 5.3±5.6, continuers: 6.9±6.0, $p > .05$