FROM PROTOCOLS TO PATIENT PREFERENCE: WHAT'S DRIVING IUI CYCLE CANCELLATIONS

Kusha Shirani, BSc (Candidate); Mehrnoosh Faghih, MD; Shilpa Amin, MD; Stacy Deniz, MD; Megan F. Karnis, MD; Michael S. Neal, MSc
McMaster University, Hamilton, Ontario, Canada, One Fertility, Burlington, Ontario, Canada

Background

Cycle cancellations are a common challenge in assisted reproductive technology (ART), contributing to emotional distress for patients and inefficiencies in clinic workflow [1].

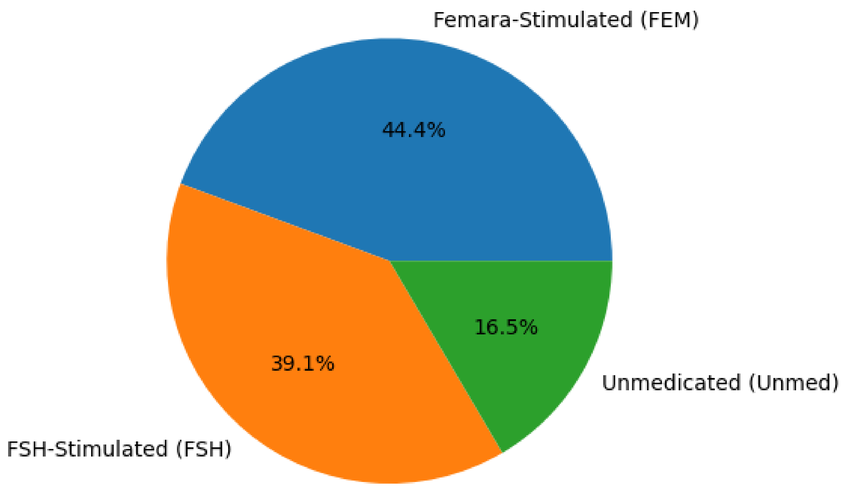
Understanding whether cancellations are driven primarily by medical risk or patient preference is essential for optimizing treatment continuity and counselling strategies.

Objective and Study Methods

To evaluate the intrauterine insemination (IUI) cycle cancellation rate across treatment modalities over a six-year period and identify the primary drivers of cancellation.

Study Design: Retrospective review
Cycles Analyzed: 6,052 IUI cycles
Time Frame: 2019-2024
Detailed Sub-Analysis: 485 cancelled cycles (Unmed, FEM, FSH); descriptive statistics evaluated cancellation drivers.

Figure 1. Cancelled IUI Cycles by Treatment Modality.

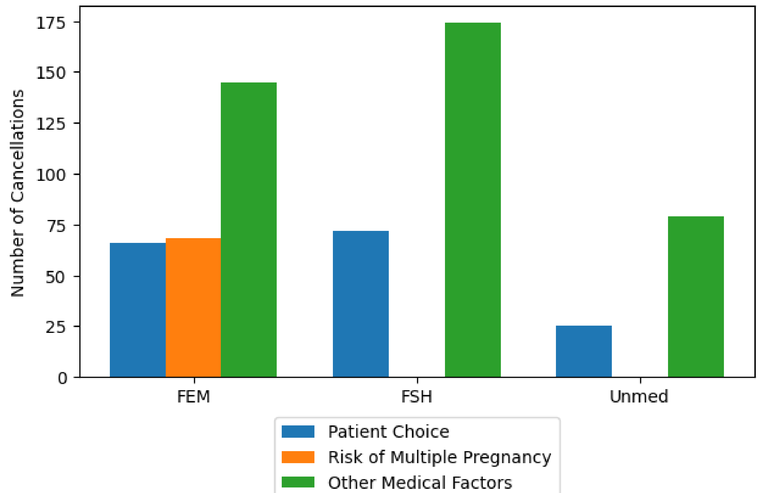


Results and Interpretation

From 2019–2024, the average IUI cancellation rate remained stable at 20.7% (±1.5 SD) across treatment modalities, suggesting consistent cancellation patterns over time. In the detailed sub-analysis, cancellations were most frequent in the Femara-stimulated (FEM) group, followed by FSH-stimulated (FSH) and unmedicated (Unmed) cycles (Figure 1).

The primary reason for cancellation differed by modality. In FEM cycles, risk of multiple pregnancy (ROM) was the leading driver (34.7%), closely followed by patient choice (33.7%), reflecting heightened ovarian response and clinical caution in stimulated cycles. In contrast, patient choice predominated in both FSH (38.9%) and Unmed (37.5%) cycles, suggesting that non-medical factors such as emotional stress, financial considerations, or timing constraints play a substantial role in treatment discontinuation.

Figure 2. Primary Causes of IUI Cancellation by Treatment Modality



Other medical factors, including premature LH surge or inadequate follicular response, accounted for smaller proportions. Only 3% of cancellations were attributed to logistical issues, indicating strong clinic protocol adherence. Collectively, these findings demonstrate that IUI cancellations are influenced by both biological risk and patient-driven decision-making, with the dominant factor varying by stimulation protocol.

Conclusion

Although the overall IUI cancellation rate remained stable, the underlying drivers differed meaningfully by treatment modality. Risk of multiple pregnancy was most prominent in Femara-stimulated cycles, whereas patient choice was the leading contributor in both FSH-stimulated and unmedicated cycles.

These findings highlight that IUI cancellations are not solely a reflection of medical contraindications but are also shaped by patient preferences and contextual factors. The low rate of logistical cancellations underscores effective clinic processes, while the prominence of patient-choice cancellations emphasizes the need for enhanced counselling, expectation-setting, and individualized cycle planning. Targeted counselling strategies tailored to treatment modality may help reduce avoidable cancellations and improve continuity of care.

Acknowledgements

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References

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