for patients who find the advanced reproductive technologies too invasive, too expensive, or inconsistent with their personal beliefs. But given the known efficacy of treatment after proper application of the advanced reproductive technologies, we believe this passive approach is poorly suited for most cases where female age is ≥35 years old. In the report by Stanford et al, it seems that more than half of the study patients agree.

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The above letter was referred to the authors of the article in question, who offer the following reply.

Response: Re: Outcomes From Treatment of Infertility With Natural Procreative Technology in an Irish General Practice

To the Editor: We welcome the opportunity to respond to the concerns raised by Dr. Sills and Drs. Walsh. Treatment with natural procreative technology (NPT) is hardly "minimalist" or "passive" and involves controlled ovulation induction and luteal-phase hormone correction for most patients, as discussed in our paper. We agree that "early diagnosis and treatment is therefore critical to optimize success." In fact, the monitoring of fertility biomarkers done for NPT frequently accelerates this process. Abnormalities of the fertility cycle can be identified early, and couples can be identified as having difficulty conceiving before 1 year.[1,2] To facilitate comparisons we eliminated these couples from our study analysis, but this is an important advantage NPT can offer to women who otherwise would have to wait 6 to 12 months to discover a problem. Although treatment with NPT can take up to 24 months, the majority of couples conceive well before this time (78% within the first 12 months in our study).

For women over age 35, live birth rates are lower for all infertility treatments including in vitro fertilization (IVF, except for donor eggs).[3] As we stated in our paper, the time frame of NPT treatment may be considered a disadvantage for some women who are approaching the end of their reproductive years. However, in our study, there were still substantial live birth rates with NPT at advanced ages (Table 4).

Dr. Sills et al express concern over the drop out rates in our study (Table 3) but do not mention that these are very similar to dropout rates in IVF studies, as we point out in our discussion and as pointed out in the paper they cited.[4,5] Studies of continuation are needed for all forms of fertility treatment.

We are surprised that Dr. Sills et al advocate for analyzing outcomes on a per cycle basis. We chose to follow the recommendations of the Cochrane Collaboration, that outcomes be reported as a pregnancy rates per woman or couple, because repeat cycle data are not statistically independent and are less relevant to the patient.[6,7] More accurate comparisons of outcomes could be made if IVF clinics followed these recommendations.

We must question Dr. Sills' claim that "some patients . . . expressed deep resentment due to the patient's perception that their referral was needlessly slow." The reference cited was simply a chart review and was very limited in the conclusions that could be drawn.[4] We also feel it is necessary to clarify that the London Daily Mail case quoted in their letter actually involved possible legal action against the Primary Care Trust, due to the 4-year delay caused by the postcode lottery system. Ironically, the patient may well have benefited from NPT treatment had it been offered to her through a specially trained general practitioner.

We agree with Dr. Sills and colleagues that "providing comprehensive information to patients about treatment options is the cornerstone of the patient-physician relationship." Patients suffering from infertility deserve to be made aware of the options available to them, including NPT. At any age, couples should be given the best possible data for outcomes to make their own choices about treatment.

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