Patient Information

Royal Devon and Exeter
NHS Foundation Trust

Sterilisation for Women at The Royal Devon and Exeter Hospital

What you need to know

Key points

Sterilisation is a permanent and irreversible way of preventing pregnancy. It involves having an operation to block, seal, cut or remove the Fallopian tubes.

The commonly performed method available for women is:

- Laparoscopic sterilisation, usually performed with Specially designed (Filshie) clips via keyhole surgery under general anaesthetic.

Sterilisation for men is called vasectomy. (See separate leaflet)

Sterilisation does occasionally fail, resulting in pregnancy.

All women thinking about sterilisation should also consider the alternative Long Acting Reversible Contraceptive options, (LARC), which are safer, in some cases more effective, and reversible.

When women undergo sterilisation and stop their previous contraceptive method, their natural period pattern will return. This can be heavier than expected and sometimes needs treatment. As the Mirena coil is also a very effective treatment for heavy periods, and its contraceptive effectiveness equals or exceeds a sterilisation operation, its use as a safer alternative should always be considered.

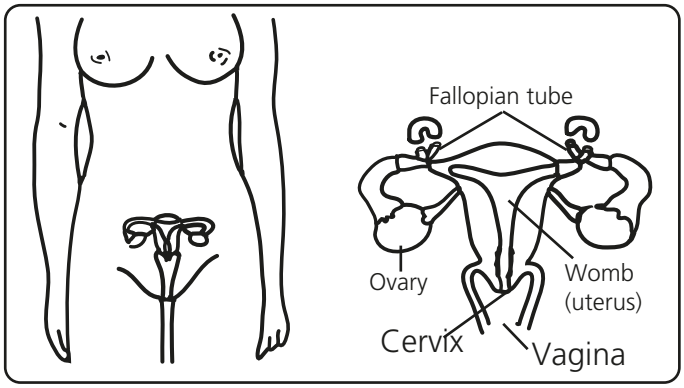
About this information

This information is based on guidance produced by the Faculty of Sexual & Reproductive Health and adapted for the service provided at the Royal Devon and Exeter Hospital.

Some of the recommendations here may not apply to you; this could be because of some other illness you have, your general health, your wishes, or some or all of these things. If you think the treatment or care you get does not match what we describe here, talk about it with your doctor or with someone else in your health care team.

What is tubal occlusion?

Tubal occlusion is an operation that blocks, seals or cuts the fallopian tubes; this means that the eggs and sperm cannot meet.



How is tubal occlusion performed?

Laparoscopic sterilisation, usually performed with clips via keyhole surgery under general anaesthetic.

Occasionally tubal occlusion is performed through an open incision in the abdomen, if for example laparoscopic surgery would be dangerous, or if an open operation is being performed anyway such as at the time of Caesarean Section.

Laparoscopic sterilisation is usually undertaken as a day case in hospital. That means you arrive and go home again on the day that you have the operation. It is performed under general anaesthetic. You may also be given a local anaesthetic during the operation to relieve any pain you might feel afterwards. The surgeon will make two small cuts, one in or just below your navel and another lower down, to one side, or just above the bikini line.

The most common procedure involves placing 'Filshie' clips onto each of the Fallopian tubes. This procedure has been widely performed for many years in which time data has been collected to know that it is effective and safe. Occasionally it is thought better to remove the tubes. This is more complex to perform, and involves an extra incision in your abdomen, but may be more advantageous in women over 30 who have a raised risk of ovary cancer. It is not thought to be more effective, and although clip sterilisation is not reversible on the NHS, it may be possible, whilst tubal removal is completely permanent. Your surgeon should tell you before the operation what methods they plan to use. Surgeons occasionally find they need to use a different method from what they had planned.

What do I need to consider?

Before having a tubal occlusion or a vasectomy, you need to be sure that you will never want to get pregnant in the future.

If you have a partner you should discuss and agree together which option suits you best as a couple. Your doctor or nurse can talk to you about your choices and help you to come to a decision. Some couples, for example, choose vasectomy rather than laparoscopic tubal occlusion because the operation is less risky and there is less chance of getting pregnant again.

Research has shown that you are more likely to have regrets later on if you are under 30 or if you do not have children already. You need to be very sure about your decision and that you fully understand what it will mean. No-one can force you to have the operation if you do not want to.

We know that there is a higher chance that women will regret their decision to have a sterilisation if they have made it during, or shortly after, a pregnancy.

If you do decide you want a sterilisation at the same time as a Caesarean, your doctor or nurse should make sure that you have been given counselling and usually would want to ensure that you have made the decision at least 2 weeks before your operation. As we can never know for certain that a baby will not have problems until it is born, it is important to know that you would not want another pregnancy even if your baby were to have problems. Sterilisation at the time of a caesarean may have a higher failure rate.

What are the alternatives?

If you are a couple you need to consider both vasectomy and tubal occlusion.

Your doctor or nurse will also tell you about the Long Acting Reversible Contraceptives (LARC). They include:

- **Contraceptive implant; Nexplanon.** This is a small flexible tube inserted under the skin of the arm. It also releases Progestogen. The implant lasts for 3 years. It has a failure rate of about 1in 2000.
- **A hormonal coil,** or intrauterine system (IUS). The most popular version is called Mirena. It releases Progestogen and lasts for 5 years. The Mirena system has a failure rate of about 1 in 2000.
- **Copper coils,** or intrauterine contraceptive device (IUCD). This is placed into your womb and has a contraceptive licence for up to 10 years. If you are over 40 when it is fitted, it can be left in until you reach the menopause. The copper coil has a failure rate of about 1 in 200.

These methods have the advantages of being safer, often more effective and reversible.

How effective is sterilisation?

Sterilisation fails if the tubes that have been cut or blocked as part of the operation join up later on. If the operation fails you can get pregnant immediately or at any time (even several years) after.

For all methods of tubal occlusion, there will be around one pregnancy in every 200 procedures that are carried out. Over a period of ten years, two or three out of every 1000 tubal occlusions using a method called 'Filshie clips' (the most common method in the UK) resulted in pregnancy.

If you get pregnant after a tubal occlusion there is a chance that the pregnancy will develop in the Fallopian tube rather than in the womb. This is called an ectopic pregnancy.

There may be a slightly higher pregnancy rate in women who have a sterilisation at the same time as a Caesarean.

How long do I need to use alternative contraception for?

We advise women to continue using alternative methods of contraception until after their next period. This is to prevent the small chance that an egg may have moved through the tube, beyond the point that it is occluded, at the time of the operation.

You will be asked to do a pregnancy test before the operation. However, it may not show up a very early pregnancy.

Can it be reversed?

All sterilisation operations are meant to be permanent. The chances of an operation to reverse it being successful vary a great deal. There is no guarantee of success. The best chances of successfully reversing a tubal occlusion seem to be when clips or rings have been used.

Tubal occlusion and vasectomy are free through the NHS but you will usually have to pay to have the operation reversed.

Laparoscopic tubal occlusion: what are the risks?

A few women have problems (known as complications) during or after the operation. Your surgeon should tell you more about these risks. All operations carry some risk, but the risk of serious complications is low. You are most at risk of complications if you have had abdominal surgery before or if you are very overweight, or if there has been previous pelvic infection. It is not possible to list all possible complications

The following are particular risks.

1. Unexpected pregnancy.

Following sterilisation there is a greater risk of the pregnancy being ectopic (that is, it develops in the fallopian tube rather than in the womb).

You should contact a doctor or nurse as soon as possible if:

you think you might be pregnant; or

you have sudden or unusual pain in your abdomen; or

you have any unusual vaginal bleeding; or

a light or delayed period.

2. Open surgery (laparotomy).

Most complications are minor and can be dealt with during the operation. Some, however, such as injuries to the bowel, bladder or blood vessels, can be more serious and as a result of them some women may need to have a laparotomy (which involves making an opening in your abdomen through either a bikini line or a midline cut). Bowel injuries are rare but they can be very serious. The chance of a serious injury during the placement of the telescope into your abdomen Is thought to be 2-4 per thousand.

3. Injury to the ovaries.

These lie very close to the tubes and can sometimes be injured. This is unusual. Very occasionally they may need to be removed.

4. Pain following the procedure.

This usually settles within a few days.

5. **Bleeding and infection of the laparoscopic incision sites.**

The majority of women who choose to have a laparoscopic sterilisation as a day case procedure make a full and rapid recovery without complication and are pleased with their treatment.

Further information

Other organisations

This organisation offers support.

FPA (Family Planning Association)
50 Featherstone Street
LONDON EC1Y 8QU
Tel: 0845 310 1334
www.fpa.org.uk

Sources and acknowledgements

This information is based on the following guideline produced by the Faculty of Sexual & Reproductive Health:

Male and Female Sterilisation Summary of Recommendations Clinical Effectiveness Unit September 2014