Surgical Threshold Policy

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Sterilisation

Definition

Sterilisation is a procedure that permanently removes an individual's fertility. Sterilisation can be carried out on a male (vasectomy) or female (normally by tubal occlusion).

Policy

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy.

NOTE: Vasectomy is funded when the criteria below are met only by referral to a community provider. For Vasectomy referrals to a secondary or tertiary care provider clinicians must apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the referral proforma.

Referral to secondary care for female sterilisation is funded when the criteria below are met. Where the criteria are not met or for referral to a tertiary care provider, exceptional funding is required.

Men or women wishing to receive sterilisation must fulfil the following criteria:

- For couples, male sterilisation (vasectomy) should be carried out in preference to female sterilisation. The benefits of vasectomy should be discussed with all women seeking female sterilisation.
- Sterilisation should be discussed with both partners whenever possible.
- They understand that the sterilisation procedure is irreversible and the reversal of sterilisation operation would not be routinely funded on the NHS.
- They are certain that their family is complete OR that they will never want children.
- They have sound mental capacity for making the decision. Additional care must be taken when counselling people under 30 years of age or people without children who request sterilisation; this should include attempts to identify coercion.
- They have received counselling about the availability of alternative, long-term and highly effective, contraceptive methods and females have been offered a trial of long-acting reversible contraception.
- They understand that after the procedure they will be required to use effective contraception until sterilisation has been confirmed: in men one negative semen sample at least 12 weeks after the procedure or until the menstrual period following the operation in women.
- They understand that sterilisation does not prevent against the risk of sexually transmitted infections.

Smoking
Patients who smoke should be advised to attempt to stop smoking and referred to stop-smoking services – **see stop smoking policy.**

Rationale and Evidence

This policy is intended to ensure sterilisation is only carried out after appropriate discussion of alternatives and agreement that vasectomy for their partners is not preferable. Vasectomy has a low failure rate, is a less invasive procedure and has fewer complications compared to procedures for female sterilisation[1].

Counselling by a trained professional is of immense importance in supporting patients to make an informed decision about sterilisation. Studies have found that 5% to 20% of women who undergo female sterilisation have regretted this decision either because of a change of relationship or a change of mind. Studies show that young age is one of the strongest predictors of regret (including request for reversal information and obtaining reversal) that can be identified before sterlisation[2-4].

The rationale for a trial of long-acting reversible contraceptive (LARC) is that it provides women with more options, a 'cooling off' period. The NHS Fertility Policy states that couples are ineligible for fertility treatment if previous sterilisation has taken place (either partner) even if it has been reversed. LARC are as effective as sterilisation and have the advantage that they are reversible. There may be additional menstrual benefits with the LNG-IUS (such as the Mirena®). This is also in line with NICE Clinical Guideline (CG30) on Long Acting Reversible Contraception 2005.

It is, therefore, important that women requesting sterilisation understand that this procedure is considered irreversible and have tried other long term methods first[5, 6].

In addition, the RCOG UK National sterilisation guidelines 2004 state that tubal occlusion should be performed after an appropriate interval following pregnancy wherever possible. Should tubal occlusion be requested in association with pregnancy (either postpartum or post abortion), the woman should be made aware of the increased regret rate and the possible increased failure rate[1].

References

1. Royal College of Obstetricians and Gynaecologists. Male and Female Sterilisation, Evidence-based Clinical Guideline Number 4, January 2004.
2. Wilcox L S, Chu S Y, Eaker E D, Zeger S L, Peterson H B. Risk factors for regret after tubal sterilization: 5 years of follow-up in a prospective study. Fertility & Sterility.1991;55:927-933.
3. Thranov I, Kjersgaard A G, Rasmussen O V, Hertz J. Regret among 547 Danish sterilized women. Scandinavian Journal of Social Medicine. 1988;16:41-48.
4. MacKenzie Z, et al. Failure and regret after laparoscopic filshie clip sterilization under local anaesthetic. Obstet Gynecol. 2009 Feb;113(2 Pt 1):270-5.
5. Killick S. Female sterilisation versus other long-term methods of contraception. Gynaecology forum. Department of Obstetrics and Gynaecology, University of Hull, UK www.medforum.nl.
6. NICE Clinical Guideline (CG30) on Long Acting Reversible Contraception 2005.
7. Blacks Medical Dictionary. 42nd Edition. A & C Black. London 2010.

Glossary[7]

Sterilisation: The process of rendering a person incapable of producing children.

Tubal occlusion: The process of ligating (tying off) or cutting and then tying the fallopian tubes that carry ovum from the ovary to the uterus (womb).

Policy effective from:	Edit to policy to clarify referral to a commissioned community provider as first line provider - approved by CPF 12 July 2018 and acknowledged by CEC 28 August 2018 Reviewed policy ratified by GB 9 January 2018 Reviewed policy approved by CEC 12 December 2017 Reviewed policy approved by CPF 10 November 2017 Policy adopted by CCG 1 April 2013 March 2018
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