North West Anglia NHS Foundation Trust

Information leaflet for patients undergoing

Laparoscopic Tubal Sterilisation

This leaflet is a guide to inform you about the operation of tubal sterilisation. These notes will give you an idea of what it will be like during your stay in hospital, and supply you with advice for when you go home. If you want to know any more, please feel free to ask members of staff.

For a pregnancy to begin a man's sperm must join with a woman's egg cell. This usually takes place at the end of one of the Fallopian tubes that connect the ovaries to the womb. All methods of sterilisation for a woman block or remove these two tubes. There are alternatives to sterilisation but if you are reading this leaflet you are probably considering sterilisation as a final and permanent method of contraception.

What do I have to consider?

- A sterilisation operation should be considered as a permanent and irreversible contraceptive method. Although technically it has been reversed in the past, it is rarely successful and can lead to complications. Furthermore it has been decided that trying to reverse the operation is not a worthwhile use of NHS resources. You must therefore be very certain that you don't want to have any children and you will never want to have children in future. We find that women who do change their mind are often those in rather unsettled circumstances when they have the operation performed. If you happen to be in that position yourself, you may need to think even harder about whether you are making the right decision.

- The sterilisation operation, like any method of contraception, can occasionally fail. The risk of this is small. We expect that approximately one woman in every 200 who have the operation performed may find that it fails at some point. The Mirena IUS, Contraceptive injection, contraceptive implant and male sterilisation all have lower failure rates than female sterilisation.

- If, after having the operation, you have any suspicion that you may be pregnant you must go to your General Practitioner (GP) promptly. You will then be checked and a pregnancy test and scan arranged to see if you are pregnant. If you are, there is a possibility that the pregnancy may be stuck in the Fallopian tube rather that in the womb. This is called an 'ectopic' pregnancy and usually requires a further operation or occasionally it can be cured by using medical treatment.

- If the sterilisation fails it is also possible for the pregnancy to be in the womb and for the baby to develop normally and result in a healthy delivery. Alternatively some women seek termination of pregnancy if the sterilisation fails.

What does it involve?

If you are young, fit and well it likely that the operation will be a day case procedure. In other words, you may be admitted to hospital in the morning and if you are feeling well enough and have recovered from the anaesthetic, you will go home the same evening.

Some women do need to stay overnight if they have certain medical problems or if they have not fully recovered from the anaesthetic.

We apply one metal clip on each fallopian tube.

An alternative method of sterilization consists of removing both your fallopian tubes. This is a called bilateral salpingectomy. This involves a third small cut on the right side of your tummy near the hipbone. Both tubes are removed. The failure rate is theoretically lower, however it is still not zero. The small stump of the tube could potentially re-open and allow a pregnancy to occur.

Sometimes the Fallopian tubes cannot be seen easily due to scarring from other operations or if you have had infection in the past. If this is a possibility, before your operation we will have discussed with you whether you would like us to make a bigger cut on your tummy to get a better view. This will usually be along the bikini line. After this you would need to stay in hospital for about two days.

Can it be done during my Caesarean section operation?

Yes, we can put clips on your Fallopian tubes if you are having a Caesarean section, particularly if it is a planned ('elective') operation. The failure rate may be slightly higher, as the tubes are a bit larger during pregnancy. As we would have to handle the tubes, and the veins near the tubes, there may be a slightly greater chance of a clot forming in the veins (a thrombosis), so we sometimes advise injections to reduce this risk.

Are there any alternatives?

Female sterilisation is the only permanent method of contraception for a woman but it is not the most effective. As mentioned earlier, the Mirena IUS, contraceptive implant and injection are all more effective and have the advantage that they are fully reversible. They are not associated with any of the surgical or anaesthetic risks of a sterilisation operation.

A Mirena IUS can be fitted in most women, either at their GP surgery or a local family planning clinic. It does not usually require any anaesthetic and although it can be uncomfortable the procedure does not last longer than 10 minutes. The chance of getting pregnant with an IUS is less than 1 in 1000 (compared to 1 in 200 for sterilisation) and the IUS is effective for up to 5 years.

The contraceptive implant is also more effective than sterilisation with a failure rate of < 1 in 1000. This is fitted in the upper arm by the GP or family planning clinic using a small amount of local anaesthetic, taking less than 1 minute. It lasts for 3 years and is removed in the same way.

A contraceptive injection is given every 12 weeks and has a failure rate of less than 4 in 1000. Male sterilisation is also more effective than female sterilisation with a failure rate of less than 1 in 2000. It is also safer for the patient, as it is done under local anaesthetic. It takes 3 months to work and is also irreversible. It is possible that you have tried all these methods of contraception and have decided that you want to be sterilised. We would expect you to wait until your youngest child is a year old before taking that step.

What will happen during the operation?

The operation is carried out under a general anaesthetic (please refer to the anaesthetic information sheet that you have been given). Sterilisation is carried out using an instrument called a laparoscope, which is a form of small telescope. Two small cuts (about 1.5cm long) are made in the abdomen. One cut is made below the tummy button and the other is made lower down near the pubic hairline.

The laparoscope is connected to a camera and screen so the inside of your abdomen can be seen. Gas is pumped through the cuts into the abdomen to inflate it as this makes it easier to see what is happening through the camera. The gas escapes through the cuts at the end of the operation. The surgeon puts the small clips onto the fallopian tubes, or both fallopian tubes are removed. The lower cut is used to introduce the 'clip applicator' into the abdomen or the instruments to cut out the fallopian tubes. The small cuts are

closed with a clip or stitch. The stitches may be self-dissolving or require removal once the cuts have healed. The cuts will be covered with a small plaster.

Preparation

Before you have the procedure you may need to attend a pre-operative assessment. A Surgical care Practitioner will sit down with you and ask you a series of questions to establish that you are medically fit enough to undergo the procedure. If necessary, the assessment may also include some medical tests such as a blood or urine test. If you smoke, you should stop at least 48 hours before surgery.

It is important that you use a reliable method of contraception prior to the operation. If there is a risk you might be pregnant at the time of the surgery your operation may be cancelled. All women will have a pregnancy test prior to the operation. However, this is only reliably negative 3 weeks after any episode of unprotected sex.

To reduce the risk of failure of the operation it is important you do not stop your current method of contraception until the period after the sterilization. You should carry on your contraceptive pill for one more month. If you are having a coil removed at the time of the sterilization you must not have sex for at least one week before the operation.

You should not go home unaccompanied after your operation so you need to organise somebody to go home with you. Prior to going into theatre you will see a healthcare professional who will check your consent form and ensure you are happy to proceed with surgery. When you arrive in theatre, both the anaesthetist and surgeon will make a final check to ensure you fully understand the procedure. Do not be afraid to ask them questions if you do not understand.

Discomfort and after-effects

After this procedure, we will try to get you mobile as soon as we can to help prevent complications from lying in bed. Typically, you will be able to get up after one hour. You will normally be discharged on the same day as your operation. You will probably still be feeling some discomfort when you are back home. Ordinary painkillers such as paracetamol should help. If the pain becomes distressing, please contact your GP.

Risks and complications

All operations carry a small risk of side effects such as pain, bleeding and infection. The risks specific to this procedure are as follows:

- Bleeding (difficulty in controlling the major blood vessels during or after the operation)
- Damage to the bowel or tubes coming from the kidneys to the bladder, or to the bladder. These complications are more likely with the removal of the fallopian tubes compared to the clip application.
- If any complications occur the surgeon may decide to perform open surgery (laparotomy). Every effort is made to reduce the chances of this happening.
- Being sterilised is one of the safest forms of contraception but still has a small failure rate as discussed above. If you miss your period contact your GP as soon as possible since, if pregnancy does occur, there is more change of pregnancy occurring in the fallopian tubes (ectopic pregnancy). Failure can occur in the months following the operation or many years later.

Please remember that if you have any questions or concerns, all staff will be happy to answer these for you.

Contact Details:

Hinchingbrooke Hospital Huntingdon, PE29 6NT **Procedure Unit** Telephone: 01480 428958 **Daisy Ward** Telephone: 01480 428959	**Peterborough (City Hospital)** **The Emergency Gynaecology Assessment Unit (EGAU)** Women's Health Outpatients, Bretton Gate, PE3 9GZ Telephone: 01733 673758 Open: Weekdays 0800-1800-phone line open until 1730 Weekends/Bank holidays 0800-1200
For emergencies only, out of these hours, please attend the Emergency Department	

Within this leaflet we use the term woman/women, however we acknowledge that it is not only people who identify as women for whom it is necessary to access our services. We recognise the importance of providing inclusive and respectful care to all people and their families, including those whose gender identity does not align with the sex they were assigned at birth. Please let us know if there is anything we can do to make you feel more comfortable while you are under our care