Interval Female Sterilization

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Question 1:

How do a patient’s medical comorbidities and surgical history affect the preoperative counseling and selection of the interval sterilization procedure that is most appropriate for her?

Response from Drs. Stuart and Ramesh:

Preoperative counseling includes discussion of the options of long-acting reversible contraceptive methods (which avoid risks of surgery), male sterilization, and options for tubal disruption, salpingectomy, and hysteroscopic sterilization. While prior medical and surgical history, including obesity, or history of multiple prior surgeries may influence preoperative surgical counseling and planning, ultimately very few patients have absolute contraindications to an interval sterilization. It is our practice to consult with colleagues who practice minimally invasive gynecology in patients with complicated surgical histories (body mass index >45, prior hernia repair with mesh, multiple prior surgeries, prior abdominoplasty) for surgical planning and intraoperative consultation, if needed.

Question 2:

Can you comment on the differences in cost of hysteroscopic sterilization versus laparoscopic tubal occlusion versus laparoscopic salpingectomy, and how this affects procedure selection, reimbursement, or cost to patients?

Response from Drs. Stuart and Ramesh:

In a retrospective cohort, Thiel et al compared the cost of laparoscopic sterilization in the operating room with hysteroscopic sterilization with in-office sedation and found that hysteroscopic sterilization resulted in a cost savings of $111 per sterilization procedure. In a cost-comparison analysis, Levine et al also found hysteroscopic in-office sterilization to be more cost effective, with a $2,075 difference compared to laparoscopic sterilization.
sterilization. However, when both procedures are performed in the operating room, costs are comparable between laparoscopic and hysteroscopic sterilization, largely due to cost of microinserts added to operating room costs.

When making decisions for type of surgery or route of surgery, we have always taken the approach that the

Question 3:

As laparoscopic techniques have become more advanced over the past few decades, the vaginal posterior colpotomy approach to interval tubal sterilization has declined. Are there patients who would still benefit from posterior colpotomy sterilization rather than a laparoscopic approach, and is there still a role for posterior colpotomy sterilization in modern-day gynecologic practice?

Response from Drs. Stuart and Ramesh:

Posterior colpotomy remains an approach to sterilization. When compared to laparoscopic sterilization, Chang et al noted that a transvaginal approach remained more technically challenging but less costly than a laparoscopic procedure. However, results of this technique are not included in modern sterilization literature and we suspect are rarely performed due to the increased comfort of and access to laparoscopy.

Question 4:

Are there differences in medicolegal concerns among the various interval sterilization procedures discussed that might also affect which procedure is selected?

Response from Drs. Stuart and Ramesh:

Like any surgical procedure, sterilization requires careful preoperative discussion regarding its permanent nature and the risks of surgery. Additionally, it is critical to counsel patients prior to hysteroscopic sterilization on the need for radiographic confirmation of tubal occlusion and interim contraception.

Question 5:

How do the presence of clips, bands, or coils affect future radiographic evaluation or surgical procedures?

Response from Drs. Stuart and Ramesh:

Future radiographic evaluation of the pelvis with:
• Clips in place: No issue with magnetic resonance imaging (MRI) and Filshie clip; will appear as surgical clips in pelvis.
• Bands in place: Would not see on computed tomography (CT) or MRI.
• Coils in place: Coil at uterotubal junction bilaterally on CT or MRI; can’t use to judge occlusion; ultrasonography and hysteroscopy most helpful for preoperative planning.

Future surgical procedures with:
• Clips in place: No issue with salpingectomy.
• Bands in place: No issue with salpingectomy.
• Coils in place: Linear salpingostomy, then remove coil and perform salpingectomy.
Question 6:

Are there any best practices to help gynecologists predict which patients are at greatest risk for not returning for follow-up hysterosalpingogram or ultrasonogram after hysteroscopic tubal occlusion?

Response from Drs. Stuart and Ramesh:

Studies evaluating compliance with follow-up after hysteroscopic sterilization are limited. While clinical trial follow-up rates exceed 90%, in clinical practice, lower income women, publically insured women, and younger patient age are associated with decreased attendance at a follow-up appointment, with reported follow-up rates as low as 13%. Electronic reminders and a designated follow-up nurse providing outreach are interventions associated with improved follow-up in these high-risk populations.

References