NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Female sterilisation for contraception request

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Female sterilisation for contraception request

Aim/ Objective of the guideline
To provide a summary of current guidance relating to female sterilisation requests

Audience
All healthcare professionals in GG&C involved in the care of women requesting permanent contraception

Guideline
The term female sterilisation is commonly used to refer to procedures intended to physically interrupt the transport of ovum released form the ovary to the uterus, thereby preventing fertilisation and pregnancy.

What are the advantages, disadvantages, and risks associated with female sterilisation?

Advantages
- It is very effective at preventing pregnancy.
- It is considered a permanent method of contraception.
- It does not rely of hormonal therapies.
- It does not rely on user memory or ongoing effort.

Disadvantages
- It requires a surgical procedure.
- Effective contraception must be continued for a period of time following sterilisation, depending on the current method used.
- People may regret having had the procedure. Regret is associated with age at time of procedure, and estimated at 12% for women younger than ≤30 years of age, compared with approx. 6% for individuals >30 years of age.
- It does not protect against sexually transmitted infections (STIs).
- Sterilisation is a permanent method of contraception and is provided on the understanding that it is an irreversible procedure. Reversal is not offered within GG&C health board.

Risks
- *Failure.* The procedure can fail, but this is uncommon. Failure may be age related, more likely in younger women with higher rates of background fertility. Overall Failure rates are estimated at approx. 0.5% (1 in 200 procedures) [9].
- *Ectopic risk.* If the procedure fails, the resulting pregnancy may be ectopic. The risk is thought to vary depending on the method used. The 10-year cumulative probability of ectopic pregnancy ranges are approx. 0.2-0.7% of procedures (2.4–7.3 per 1000 procedures).
- *General Anaesthetic and laparoscopy operative risk.* Laparoscopic sterilisation is performed under general anaesthesia, most commonly using a laparoscopic approach. This is associated with several risks and complications (see procedure specific guideline diagnostic-laparoscopy.pdf (scot.nhs.uk).
- *Menstrual symptoms, hormone levels and ovarian reserve.* Women may report worsening menstrual symptoms following tubal occlusion. It is thought this may be due to the cessation of hormonal methods of contraception, there is no evidence to suggest a direct causal effect from sterilisation procedure. There is no evidence that tubal occlusion results in significant changes to hormone levels or ovarian reserve.

Female cancers
Ovarian cancer. Tubal occlusion is not associated with an increased risk of ovarian cancer. The primary procedures offered in GG&C are bilateral tubal occlusion with Filshie clips or ligation at time of Caesarean birth. These are associated with a reduction in ovarian cancer of 13-41%. It is suggested that the protective effect may be slightly higher if bilateral salpingectomy is performed (reduction in ovarian cancer risk of 42-78%) however should be balanced by the potentially increased risks of salpingectomy vs Filshie clip application / tubal ligation procedures [6]

There is no evidence which suggests an association between tubal occlusion and risk of *breast, cervical or endometrial cancer*.

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Counselling
It is advised counselling should be complete, with documentation of discussions including consent at least 2 weeks before the procedure is carried out.

In many cases, particularly if performed as part of Caesarean birth or in younger women, the procedure can be associated with negative psychological response and regret.

Therefore, alternatives to sterilisation should be discussed. This should include failure rates, method of use and associated advantages and disadvantages of each alternative method. Up to date information regarding contraceptive choices with risk assessments can be found at the Faculty of Sexual and Reproductive Health (www.fsrh.org).

Suggested proforma for counselling can be found in Appendix 1.

Techniques
Sterilisation can be performed a number of ways. No particular way has been shown to be superior in term of failure rate. The exception is bilateral salpingectomy, where pregnancy following the procedure is extremely rare. [7]

The fallopian tubes can be accessed via laparoscopy, mini-laparotomy, and during caesarean section operation. The transcervical route for hysteroscopic sterilisation using flexible Essure® micro-inserts has now been discontinued, and is not available.

The fallopian tubes can be completely or partially removed, ligated, or occluded (tubal ring or clip). Where the tube is removed (partial or complete), it *must* be sent to pathology to confirm tissue removal.

Where Filshie clips are applied to the tubes, the routine use of more than one clip on each tube is not recommended by FSRH. It is good practice to obtain photographic evidence of Filshie clip application to fallopian tubes and include within the patient notes.

Mini-laparotomy is rarely performed but can be used if laparoscopic access has failed or is contraindicated.

Tubal occlusion, ligation or partial salpingectomy at time of Caesarean birth, may be associated with higher rates of failure, but it is difficult to be certain about outcomes in this population.

Sterilisation after previous failed procedure
Where there has been failure of a previous sterilisation procedure, the options for ongoing contraception should be discussed, including all suitable alternative methods.

Where female sterilisation remains the method of choice for the patient, a second operation would be performed either as a distinct procedure in gynaecology, or as part of a Caesarean birth.

The second operation should be performed by a different practitioner to the primary surgery.
Photographs should be obtained and witnessed detailed confirmation of operative findings should be documented in patient notes.

Where possible, performing bilateral salpingectomy should be the procedure of choice in any second operation to achieve sterilisation.

Fallopian tubes *must* be sent to pathology to confirm their removal.

References:

1. Scenario: Female sterilization (tubal occlusion) | Management | Contraception - sterilization | CKS | NICE
2. consent-advice-3-2016.pdf (rcog.org.uk)
3. Patient Agreement to Investigation or Treatment Consent Form | Diagnostic Laparoscopy, GGC diagnostic-laparoscopy.pdf (scot.nhs.uk)
4. cec-ceu-guidance-sterilisation-cpd-sep-2014 (1).pdf

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5. Danvers AA, Evans TA. Risk of Sterilization Regret and Age: An Analysis of the National Survey of Family Growth, 2015-2019. Obstet Gynecol. 2022 Mar 1;139(3):433-439. doi: 10.1097/AOG.0000000000004692. PMID: 35115436. Ely LK, Truong M. The Role of Opportunistic
6. Bilateral Salpingectomy vs Tubal Occlusion or Ligation for Ovarian Cancer Prophylaxis. J Minim Invasive Gynecol. 2017 Mar-Apr;24(3):371-378. doi: 10.1016/j.jmig.2017.01.001. Epub 2017 Jan
7. Spontaneous Pregnancy after Total Bilateral Salpingectomy: A Systematic Review of Literature, Tanja Baltus, James Brown, Sujana Molakatalla, Supuni Kapurubandara, Journal of Minimally Invasive Gynecology, Volume 29, Issue 2, 2022, Pages 213-218,10. PMID: 28087480.
8. cec-ceu-guidance-sterilisation-summary-sep-2014.pdf
9. Comparative effectiveness of contraceptive methods | Background information | Contraception - assessment | CKS | NICE

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Counselling record for female sterilisation

PATIENT

LABEL

Date : _____

Age	
Parity and previous mode of delivery	
Previous and current Contraceptive Methods	
Menstrual cycle	
Medical and surgical history	
Alternative methods* *Failure rates expressed as % of women with unintended pregnancy in first year of perfect use (and typical use) Figures from NICE [9]	**Discussed**
Vasectomy – * failure rate 0.1% (0.15%), can be done under LA	☐
IUS (52mg LNG IUS) – * failure 0.2% (0.2%), useful for HMB, can be used as progesterone component of HRT(Mirena®), GA not usually required, reversible, if <45year can be used for 8 years for contraception, but only 5 years for HMB or HRT (Mirena®), there is an expulsion rate of 5% of insertions which may be higher if inserted <48hour postpartum	☐
Copper IUCD – *failure 0.8% (0.6%), contraceptive potential 5-10 years (depending on type of device), reversible, GA not usually required, periods may be heavier and can be associated with pain. There is an expulsion rate of 5% of insertions which may be higher if inserted <48hour postpartum	☐
Etonogestrel Subdermal Implant – *failure 0.05% (0.05%), effective for 3 years, local anaesthetic, initial menstrual irregularity, can be used immediately postpartum	☐
Injectable depot medroxyprogesterone acetate (DMPA) – * failure 0.2% (6%), 12 weekly injections, can be used immediately postpartum	☐
Combined hormonal contraception (pill,patch, vaginal ring) – *failure 0.3% (9%), suggest tailored regimes, if postpartum start day 21 if not breast feeding	☐
Progesterone only pill (desogestral) – *failure 0.3% (9%), can start immediately postpartum	☐

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Risks with sterilisation	**Discussed**
Permanent and Irreversible	☐
*Failure rate 0.5%	☐
Ectopic pregnancy	☐
Periods unchanged	☐
Feelings of regret	☐
Aware to continue current contraception	☐
Sterilisation may not be possible if emergency caesarean or intraoperative complications and alternative methods of contraception will be offered	☐
Consent obtained (including method offered and agreed)	☐
Written information given	☐
Name, Signature and Grade	

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