LOW PRIORITY THRESHOLD PROCEDURE T26

Female Surgical Interval Tubal Sterilisation

Policy Summary

Female sterilisation will be available once the patient has received counselling about her contraceptive options and either turns down or accepts a trial of a Long Acting Reversible Contraceptive (LARC) and found it unsuitable. LARC methods include the levonorgestrel intrauterine system (LNG-IUS) (such as the Mirena), the etonogestrel (progesterone only) subdermal implant (POI) (such as the Implanon) or the Depot medroxyprogesterone acetate injection (DMPA) (such as the Depot Provera).

Referral Criteria

Referrals for sterilisation will generally be accepted if points one, two and three plus either of four, five or six are met.

1. Is the woman certain her family is complete or that she never wants children? Is the woman aware that the procedure is considered permanent and that reversal is not routinely funded on the NHS?
2. Has the woman received counselling about her options including consideration of all other forms of long-acting contraceptives and her other contraceptive options? If she has a partner, has he considered vasectomy?
3. Does the woman have sound mental capacity? (Please see RCOG UK National sterilisation guidelines 2004*)
4. Has the LNG-IUS, POI or DMPA been used for a flexible 12 month trial*?
5. The woman has a medical condition making pregnancy dangerous.
6. The woman declines a trial of long-acting reversible contraception after counselling.

* Flexible 12 month trial

If the patient wishes to accept a trial of a LARC method, she will be offered a flexible 12 month period unless extending the trial to 12 months would not be of benefit to the patient (i.e. the side effects are affecting the patient’s quality of life). Under these circumstances, the decision will be based on clinical judgment to reduce the trial to 6 months. This offers clinical flexibility so that the individual clinician can take the patient’s specific circumstances into account when making the decision.

In addition

Patients with a BMI of 30 and above should receive advice and support to aid weight loss prior to admission for sterilisation in order to reduce anaesthetic and post-operative complications.

If a woman does not wish to try a LARC, they must receive counselling about these methods from a healthcare professional experienced in fitting these devices. If all these methods are not offered “in house” the woman should be referred to one of the practices offering LARC methods.
as an enhanced service. If after such counselling the woman still declines to try a long acting reversible contraceptive method then sterilisation will be accepted.

If a woman has a personal history of breast or other hormonal cancer and wishes to avoid all hormonal methods then a copper intrauterine device (IUCD) should be suggested for the trial in point 4 above.

**Exceptions to this policy include the following:**
- Where sterilisation is to take place at the time of another procedure such as caesarean section (counselling and consent should have been given at least one week prior to the procedure).
- Where there is a contraindication to the use of a LARC
- Where there is an absolute contraindication to pregnancy

**Rationale for decision**

Expert counselling is extremely important. Regret rates after female sterilisation are quoted as between 5% and 20% often because of a change of relationship or just a change of mind. It is therefore important that women requesting sterilisation understand that this procedure is considered irreversible and have tried other long term methods first. This is in line with the NICE Clinical Guideline on Long Acting Reversible Contraception 2005 [CG30].

Over a 15 year period (the average length of contraception needed), sterilisation is more cost-effective after 5 years compared with all other forms of long-acting contraception. This is due to the discontinuation rates suggested for long-acting reversible contraceptives. If there was no discontinuation then long-acting reversible contraceptives would become cost-effective compared with sterilisation. Therefore it is important that counselling for long-active reversible contraception is realistic and addresses the patient’s expectations.

A number of women post-sterilisation experience heavy menstrual bleeding (HMB). After ruling out pathological and histological abnormalities, Clinicians work with patients to find the most suitable treatment. The cause of post-sterilisation HMB could be due to discontinuation of the effective treatment for HMB, the previous contraceptive method used by the patient, such as the combined oral contraceptive pill, the LNG-IUS and DMPA injections which, for most, had given light or no periods. A cohort study published in ‘Obstetrics and Gynaecology’ 1998, identifies that sterilised women may be less comfortable accepting medical management (such as oral contraceptive use) for abnormal uterine bleeding (HMB). Women who had been sterilised were more likely than women whose husbands had had vasectomies to undergo a hysterectomy 5 years of sterilisation.

NICE Clinical Guideline Heavy Menstrual Bleeding 2007 describes the processes for the investigation and treatment of heavy menstrual bleeding (HMB). Focusing on treatment, NICE identify the LNG-IUS as an effective treatment for HMB. NICE guidance states that hysterectomy should not be used as first line treatment solely for HMB unless there is the presence of large fibroids or other symptoms. The failure rate of the LNG-IUS is lower at 0.1% than that of female sterilisation at 0.5% and the LNG-IUS has been shown to be an effective treatment for HMB.

Sterilisation is not completely excluded because it can be the most cost-effective option and may be the most clinically appropriate method for some women. The rationale for a trial of long-acting reversible contraceptive is that it provides women with more options, a “cooling off” period and if they find the long-acting reversible contraceptive acceptable it would become the more cost-effective option. Similarly, sterilisation is available to women who do not wish to have a trial of long-acting reversible contraceptive because it is likely that these women would discontinue the long-acting reversible contraceptive.
Other Reasons for developing this threshold policy on female sterilisation are as follows:-

- Sterilisation involves an invasive operation.
- Sterilisation is not a temporary method of contraception.
- East of England NHS states that couples are ineligible for fertility treatment if previous sterilisation has taken place (either partner) even if it has been reversed. East of England Specialist Commissioning Group, Fertility Services Commissioning Policy, NHS East of England, Author C. Young Associate Director (Acute Services) Specialised Commissioning Group, August 2008
- 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).
- Some women regret undergoing sterilisation, particularly if they enter into new relationships.

In addition the RCOG UK National sterilisation guidelines 2004 suggest that:

1. If there is any question of a person not having the mental capacity to consent to a procedure that will permanently remove their fertility, the case should be referred to the courts for judgment.
2. Additional care must be taken when counselling people under 30 years of age or people without children who request sterilisation.
3. 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.

This policy was developed based on a review of published evidence, guidelines and consensus statements, in consultation with local primary and secondary care clinicians, community representatives, clinical commissioners, and commissioning managers.

References

(1) Royal College of Obstetricians and Gynaecologists (RCOG). Male and female sterilisation. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2004 Jan. 114 p. (Evidence-based Clinical Guideline; no. 4)


(3) F. Lakha, A. Glasier, Continuation rates of Implanon® in the UK: data from an observational study in a clinical setting. Contraception 2006. 74 (4) 287-289

(4) NICE: Heavy Menstrual Bleeding: Clinical Guideline 44. January 2007

(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


(8) NICE: Heavy Menstrual Bleeding: Clinical Guideline 44. January 2007