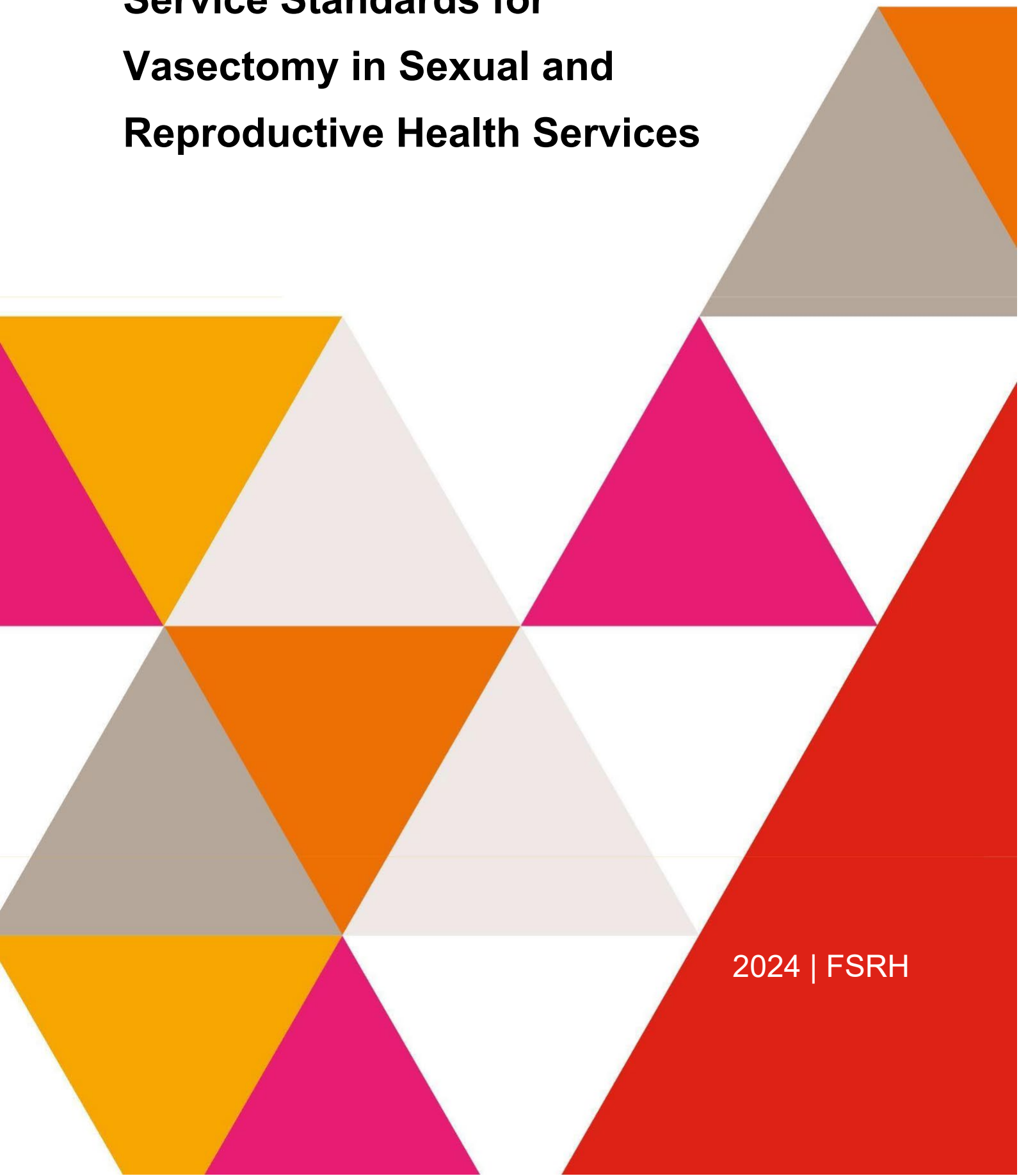
FSRH The Faculty of Sexual & Reproductive Healthcare

Service Standards for Vasectomy in Sexual and Reproductive Health Services



2024 | FSRH

The Faculty of Sexual and Reproductive Healthcare (FSRH) is the largest UK professional membership organisation working in the field of sexual and reproductive health (SRH). We support healthcare professionals to deliver high quality healthcare, including access to contraception. We provide our 15,000 doctor and nurse members with National Institute for Health and Care Excellence (NICE) accredited evidence-based clinical guidance, including the UKMEC, the gold standard in safe contraceptive prescription, as well as clinical and service standards.

The FSRH provides a range of qualifications and training courses in SRH, and we oversee the Community Sexual and Reproductive Healthcare (CSRH) Specialty Training Programme to train consultant leaders in this field. We deliver SRH focused conferences and events, provide members with clinical advice and publish *BMJ Sexual & Reproductive Health* – a leading international journal. As a Faculty of the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK, we work in close partnership with the College but are independently governed.

The FSRH provides an important voice for UK SRH professionals. We believe it is a human right for everyone to have access to the full range of contraceptive methods and SRH services throughout their lives. To help achieve this we also work to influence policy and public opinion working with national and local governments, politicians, commissioners, policy makers, the media and patient groups. Our goal is to promote and maintain high standards of professional practice in SRH to realise our vision of holistic SRH care for all.

www.fsrh.org

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Faculty of Sexual and Reproductive Healthcare, of the Royal College of Obstetricians and Gynaecologists and in conjunction with Association of Surgeons in Primary Care.

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SERVICE STANDARDS FOR VASECTOMY IN SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Introduction

This standard provides guidance on the best practice for healthcare professionals and commissioners delivering a vasectomy service to ensure safe, efficient, and effective healthcare that is patient-centred and equitable.

Unlike the specific guidance for Male and Female Sterilisation, this is not a tool to support clinical decision making, nor is it designed to be prescriptive in the information required to make such decisions. The role of this document is to address the factors required to create an environment conducive to both the healthcare professional and patient obtaining accurate, relevant, and concise information. This will facilitate the clinical decision.

This standard should be considered for all those involved in providing vasectomy services, whether in secondary care or the community, whether under local or general anaesthesia.

1 What is Vasectomy?

Vasectomy is the technique of interruption of the vas deferens with an intention to provide permanent contraception by blocking the passage of sperm produced by the testes. The procedure is usually performed under local anaesthesia. The traditional method involves making one or two incisions in the scrotal skin to expose each vas deferens. Each vas deferens is then occluded and divided using various techniques.

A technique to isolate and occlude the vasa was developed by Li et al in 1991[1] titled 'no-scalpel vasectomy' (NSV), where a single central puncture wound is made in the scrotal skin to access and occlude each vas. This method was developed to increase the acceptability of vasectomy by eliminating the fear of scalpel incision and is now referred to as a minimally invasive vasectomy (MIV).

A number of NSV techniques are reported in the literature. It has been suggested that these techniques should not be referred to as NSV but instead be referred to as minimally invasive vasectomy (MIV). For the purposes of this standard, the term MIV will be used to encompass NSV and any modified versions of this technique where the skin opening is ≤10 mm, and the dissection area surrounding the vas deferens is minimised and does not require the use of skin sutures. MIV may include the use of a variety of surgical instruments, including a scalpel, to expose the vas.

[1] Li SQ, Goldstein M, Zhu J, Huber D. The no-scalpel vasectomy. J Urol 1991; 145: 341–344.

2 Vasectomy Services in the UK

Commissioners should note these standards when specifying the requirements of issuing contracts for vasectomy services

Vasectomy services have largely been moved from secondary care settings into the community, with most now being provided in the community, in GP surgeries and sexual health clinics (within both NHS and private organisations). Up to now, there has been little or no monitoring by Commissioners of these community vasectomy services, although many require annual returns. Many commissioners are unfamiliar with quality standards other than those monitored by the CQC (Care Quality Commission), though this is now increasing with various bodies such as Clinical Commissioning Groups, GP Federations, GP Alliances, and Integrated Care Boards having greater roles in commissioning vasectomy services and monitoring standards and contracts. There is, however, significant variation within the UK regarding the requirements placed upon individual vasectomy services.

Vasectomy services provided in sexual health clinics are currently monitored more consistently by lead clinicians / service managers, and many SRH clinicians who perform vasectomies are also members of the Association of Surgeons in Primary Care (ASPC), having access to regular updates, study days and conferences.

It is believed appropriate that the FSRH and ASPC should be consistent in the guidance on standards that are available for members of these organisations and all vasectomy surgeons, whether practicing in the community or in secondary care; consequently, these two organisations have worked together to co-develop this standard.

This standard should be used by both commissioners and providers in conjunction with the following FSRH service standards to support best clinical practice:

- Service Standards for Confidentiality in Sexual & Reproductive Health Services
- Service Standards for Record Keeping
- Service Standards for Obtaining Valid Consent in SRH Services
- Service Standards for Resuscitation in SRH Services
- Service Standards for Risk Management in Sexual and Reproductive Healthcare
- Clinical Guidelines for Male and Female Sterilisation

3 Standard Statement on Referrals / Pathway

Vasectomy services should be able to show a standard pathway from referral to discharge and completion of post-vasectomy semen analyses.
[Auditable standard 97%]

3.1 Referrals will mainly be from General Practices and Sexual Health clinics although self-referrals both private and NHS are common for some clinics.

3.2 The referrer should have a discussion with the patient and any partner (where appropriate) about the various options available for future contraception for either party, including risks and benefits, and provide relevant information on these options before referring a patient for a vasectomy.

3.3 It is for the vasectomy surgeon to ensure that the patient has received relevant and appropriate information in a timely manner so that valid consent can be obtained.

3.4 Vasectomy services should be able to show a standard pathway from referral to discharge and completion of post-vasectomy semen analyses. This should include

3.4.1 how referrals are processed

3.4.2 triaged for initial suitability (demographic and medical history)

3.4.3 timing of provision of information, any pre-operative counselling and consent (consistent with GMC Good Medical Practice and current developments in case law) prior to the operation

3.4.4 discharge procedure

3.4.5 management of complications and follow-up

3.4.6 arrangements for post-vasectomy semen analysis

3.4.7 audit and feedback.

4 Standard Statement on Counselling & Consent

There should be a documented discussion of alternative methods of contraception including long-acting reversible contraceptive (LARC) methods with patients requesting vasectomy. [Auditable standard 97%]

Written consent should be obtained. [Auditable standard 97%]

4.1 Exchange of information between doctor and patient is essential to good decision making[2].

4.2 Where appropriate, patients and their partners requesting vasectomy should be given information about other contraceptive methods including LARC. This should include information on the advantages, disadvantages, and relative failure rates of each method.

4.3 Patients requesting vasectomy can be reassured that there is no increase in testicular cancer[3] or heart disease[4] associated with vasectomy. Any reported association of an increased risk of prostate cancer has been subjected to extensive review and concluded that there may be only a very small increased risk; in any event it would be considered likely to be non-causative[5][6].

4.4 Patients must be informed about risks associated with vasectomy, including the risk of developing chronic scrotal pain which can be severe enough to impact quality of life and is a cause of patients subsequently complaining and seeking legal advice[7],[8].

4.5 Offer all relevant parties clear, consistent information and advice throughout all stages of their care[9]. This should include the risks of surgical site infections and their

2 Decision making and consent: https://www.gmc-uk.oíg/ethical-guidance/ethical-guidance-foí-doctoís/decision-making-and-consent

3 Association between vasectomy and risk of testicular cancer: A systematic review and meta-analysis. PLoS One. 2018 Mar 22;13(3):e0194606. doi: 10.1371/journal.pone.0194606. PMID: 29566037; PMCID: PMC5864054.

4 Vasectomy and cardiovascular disease risk: A systematic review and meta-analysis. Medicine (Baltimore). 2017 Aug;96(34):e7852. doi: 10.1097/MD.0000000000007852. PMID: 28834896; PMCID: PMC5572018.

5 Vasectomy and Prostate Cancer risk: a 38-year Nationwide Cohort Study01: J Natl Cancer Inst. 2020 Jan 1;112(1):71-77. doi: 10.1093/jnci/djz099.

6 Vasectomy and the risk of prostate cancer in a Finnish nationwide population-based cohort: Cancer Epidemiol. 2020 Feb:64:101631. doi: 10.1016/j.canep.2019.101631. Epub 2019 Nov 21

7 The incidence of chronic scrotal pain after vasectomy: a prospective audit. BJU Int. 2007 Dec;100(6):1330-3. doi: 10.1111/j.1464-410X.2007.07128.x. Epub 2007 Sep 10. PMID: 17850378

8 Incidence of Post-Vasectomy Pain: Systematic Review and Meta-Analysis. Int J Environ Res Public Health. 2020 Mar 10;17(5):1788. doi: 10.3390/ijerph17051788. PMID: 32164161; PMCID: PMC7084350.

9 https://www.kingsfund.org.uk/blog/2016/11/producing-quality-patient-information

management.[10]

4.6 The operating clinician should ensure that the counselling, information exchange, history, and examination have been completed, and be satisfied that the patient does not suffer from concurrent conditions which may require an additional or alternative procedure or precaution.

4.7 Information provided in the form of leaflets/websites/videos should be recorded in the clinical record along with the source. All patient information leaflets available for distribution must be kept up to date by the organisation. The date of publication (or version) of the written information provided should be noted. Patient information leaflets should be stored for 6 years after updating.[11]

4.8 Counselling should take into account cultural, religious, psychosocial, psychosexual, and other psychological issues in relation to protected characteristic groups, some of which may have implications beyond fertility. Healthcare Professionals should concentrate on factual information and avoid persuasion or any act that may be deemed coercive however clear the advantage of their recommended option appears to be.

4.9 Additional special consideration should be taken when counselling patients who may be at higher risk of later regret;[12] this would include (but not exclusively) those;

- Under the age of 30 years
- Having no children[13]
- Whose partner is currently pregnant or they have a child under the age of one year[14]
- Not in a relationship
- Experiencing conflict or a crisis in their life
- Who may be at risk of coercion
- Where there are safeguarding issues

4.10 A signature on a consent form is not a binding contract or proof of valid consent but is only evidence of a process of consent-giving. There should be recorded or written consent. Patients may, if they wish, withdraw their consent at any time.[15] Completion of a consent form is in most cases not a legal requirement.

4.11 For procedures involving significant risks, it is essential for health professionals to clearly document both a patient's agreement to the intervention and the discussions that led up to this agreement, including the provision of any patient information materials.

10 https://www.nice.org.uk/guidance/ng197/resources/shared-decision-making-pdf-66142087186885

[11]FSRH Service Standards on Record Keeping

[12]Vasectomy Regret or Lack Thereof. Health Psychol Res. 2022 Sep 15;10(3):38241. doi: 10.52965/001c.38241. PMID: 36118980; PMCID: PMC9476225

[13]Vasectomy Regret Among Childless Men. Urology. 2024 Feb;172:111-114. doi: 10.1016/j.urology.2022.11.027. Epub 2022 Dec 5. PMID: 36481202

[14]Child and infant mortality in England and Wales - Office for National Statistics (ons.gov.uk)

[15]Faculty of Sexual and Reproductive Healthcare. Service Standards for Obtaining Valid Consent in SRH Services

5 Standard Statement on Clinical Environment [16]

The clinical environment should comply with current national guidance

5.1 Every effort should be made during face to face and remote consultations to ensure the environment is comfortable and facilitates confidentiality and respect for patient dignity [17],[18],[19].

5.2 Permission must be sought from a patient if observers/students are to be present during face to face and remote consultations and during procedures. [4]

5.3 Any requests for a specific gender of healthcare professional should be accommodated as far as possible or the patient referred to alternative services if the request cannot be met and they decline to see the healthcare professional on the basis of gender. [20]

5.4 Ceilings should preferably be made from non-porous materials that can be easily cleaned. Suspended ceilings should not be installed in new facilities.

5.5 Walls should be made from non-porous/monolithic materials that can be easily cleaned and occasionally disinfected.

5.6 Mechanical ventilation is not required but openable windows should be kept closed where specialist mechanical ventilation is provided. Where there is natural ventilation using a window that can be opened, there must be a fly screen to prevent the ingress of insects. Where windows are present, these must not compromise patient privacy.

5.7 Floors should be easily cleaned and disinfected according to local policies and be durable and strong enough to support the machinery that will be necessary in some operative facilities.

5.8 Coving is desirable to facilitate cleaning, contain spills, and avoid damage. The design should minimize the deposition of dust, including appropriate racking or shelving.

5.9 For mechanically ventilated facilities, these should be within the standard range, i.e. 18–22 °C with a relative humidity of 20–60% unless clinical considerations deem otherwise.

5.10 Lighting should be adequate for the task to be undertaken in the facility.

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[16] Journal of Hospital Infection 80 (2012) 103-109)

[17] Faculty of Sexual & Reproductive Healthcare, 2016. Service Standards for Sexual and Reproductive Healthcare.

[18] 6 British Association Sexual Health and HIV, Clinical Effectiveness Group, 2013. UK National Guideline for Consultations Requiring Sexual History Taking

[19] 7 Rogstad K, Johnston G, 2014. Spotting the Signs: A National Proforma for Identifying Risk of Child Sexual Exploitation in Sexual Health Services.

[20] General Medical Council, 2018. Confidentiality: good practice in handling patient information

5.11 All facilities should have emergency lighting in the case of a loss of power supply and should comply with relevant health and safety recommendations.

5.12 A separate area for the laying up of instruments is not required, but instruments should only be laid up as required and not in advance.

5.13 Scrub up facilities may be within the operative facility, but if within the operating room/theatre, should be located such that instruments do not get splashed and should be separate from basins used for other purposes.

5.14 Taps or faucets should be hands-free.

5.15 Disposable towels should be used.

5.16 For minor procedures in the community single-use instruments eliminate the rigorous requirements to decontaminate surgical instruments to a standard that would be difficult to comply with outside specialised sterile supply departments. [21] [22]

5.17 The facilities and the procedures for the safe disposal of waste, including sharps, should comply with local guidelines for holding waste prior to collection/disposal. [23]

5.18 All patients should be offered a chaperone for any examination. If the offer is declined, this should be recorded in the patient's notes. If a chaperone is present, a record should be made of the identity of the chaperone. In most cases, this would be the healthcare professional assisting and being present with the vasectomy surgeon.

[21] Department of Health (Decontamination of re-usable medical devices in primary, secondary and tertiary care sectors (NHS and Independent Providers) DoH, London (2007)

[22] Department of Health Health Technical Memorandum 01-05. Decontamination in primary care dental practices DoH, London (2009)

[23] Department of Health Health Technical Memorandum 07-01. Safe management of healthcare waste DoH, London (2011)

6 Standard Statement on Procedure

Commissioners and vasectomy surgeons should be familiar with FSRH Male and Female Sterilisation guidance[24] and up-to-date evidence and consensus

6.1 FSRH Male and Female Sterilisation guidance discusses the various techniques available to complete a successful vasectomy with the current recommended method being MIV with cautery; simple transection and / or single tying of each vas is not recommended as it leads to an increased risk of early failure.

6.2 Vasectomies performed under general anaesthesia and where special monitoring is required (for example, electronic heart devices) should be undertaken in secondary care.

6.3 Vasectomies performed under local anaesthetic should be undertaken in the community. Local anaesthetic with or without adrenaline (epinephrine) can be used during vasectomy (bupivacaine with adrenaline use is off-label).[25]

6.4 Local anaesthetic should be administered via infiltration of the subcutaneous tissue and by direct injection around the vas deferens.

6.5 Local anaesthetic should be administered using a fine-gauge needle or MadaJet to reduce pain.

6.6 A minimally invasive approach should be used to expose and isolate each vas during vasectomy, as this approach results in fewer early complications in comparison to other methods.

6.7 Semen analysis should be carried out by an approved laboratory (See Annex 1 and 2).

[24] Faculty of Sexual & Reproductive Healthcare, 2014, Clinical Guideline: Male and Female Sterilisation

[25] FSRH Service Standards for Medicines Management in Sexual and Reproductive Health Services

7 Standard Statement on Post-Procedure

Prospective surveillance of post-procedure infections is required and should include, as a minimum, antibiotic use, and hospital admission rates for healthcare-associated infection. [Auditable standard 97%]
Following vasectomy there should be a record that continuing contraception has been advised until confirmation of fertility status and that the vasectomy has been successful. [Auditable standard 97%]
Patients who have undergone vasectomy should be provided with access (written and/or electronic) to post-procedural information that outlines appropriate self-care and instructions and emergency contact details. [Auditable standard 97%]

7.1 It is recommended that patients should not drive themselves home after the procedure. Where this is unavoidable, the patient should remain under observation in clinic for a minimum of 30 minutes, due to the small risk of post-operative syncope.

7.2 The clinic should provide all patients with details of post-vasectomy care including (but not exhaustive); emergency contact numbers (when and who to contact), pain relief, wound care, resuming normal activities including sexual intercourse, contraception prior to clearance, and seminal fluid analysis.

7.3 The clinic should advise patients on how to comply with seminal fluid analysis (SFA) and ensure all necessary equipment is provided in a timely manner.

7.4 The clinic should inform patients that they are required to provide at least one semen sample for SFA at 12+ weeks post vasectomy to determine whether or not the procedure has been successful, in line with current recommended evidence and consensus (See Annex 1 and 2).

7.5 The vasectomy service should communicate SFA results to the patient, their registered General Practitioner and referrer if appropriate.

8 Standard Statement on Record Keeping

Records should be comprehensive and provide an accurate account of the consultation and evidence to support clinical decision-making. [Auditable standard 97%]

Record-keeping can be summarised as follows, but reference should always be made to both the section on Record-Keeping in GMC: Good Medical Practice [26]and also the FSRH Standard on Record-keeping.

8.1 Make clear, contemporaneous, and complete written records in the patient's clinical record as you would in a standard consultation.

8.2 Record who was present at each consultation and/or who has taken any images[27], and their relationship to the patient.

8.3 Record information given to the patient, discussions and decisions about capacity, consent, and best interest decision making.

8.4 Ensure your clinical justification for examination and non-examination is clear.

8.5 Document whether or not a chaperone was offered and either declined or was present at the consultation. If a chaperone was present, you should record their identity, including their designation and the extent of the assessment witnessed.

8.7 Operation notes must be clear and include details of any complications and any additional procedures taken.

26 Domain 1: Knowledge skills and performance - professional standards - GMC (gmc-uk.org)

[27] FSRH Service Standards for Record Keeping - July 2019

9 Standard Statement on Training and Workforce

Evidence of competency and continuing CPD should be available for all health professionals involved in providing a vasectomy service (Audit standard 97%)

9.1 Services should ensure that an appropriate skill mix of clinical staff is employed to maximise each clinician's potential and to provide a high standard of care for patients in a professional and organised clinical setting with adequate support.

9.2 All staff must be appropriately trained to fulfil the roles and duties required of them. Competency in record keeping, confidentiality, and consent are all essential for supportive administrative staff.

9.3 Any person assisting the surgeon during the operation must be trained and competent in these areas as well as in hygiene, communication, and resuscitation. This will usually be at the level of at least a Health Care Assistant (HCA).

9.4 Practitioners who are being trained to perform vasectomies should ensure their training conforms to the standard advocated by the Faculty of Sexual & Reproductive Healthcare and Association of Surgeons in Primary Care.

9.5 The SSM includes a logbook that must be completed by both the trainer and trainee during the course of training.

9.6 A certification of satisfactory completion of training confirming the vasectomy surgeon is competent and confident to carry out vasectomies independently should be issued to the successful trainee.

9.7 Allocated time within training clinics should be used for feedback and assessment with less emphasis on theoretical teaching (although this should be an integral part of learning as described in the training logbooks). Learners undertaking vasectomies should have acquired the relevant theoretical knowledge prior to clinical contact and practical training.

9.8 Trainers should have allocated time within their job plans to fulfil their educational responsibilities and develop their skills in medical education. [28]

9.9 Vasectomists should ensure clinicians in training and clinical students have appropriate workloads, learning opportunities, and clinical supervision by suitably qualified members of staff.

9.10 Guidance and how to register as a trainer is available on the FSRH and ASPC websites.

[28] General Medical Council, 2016. Promoting excellence: Standards for medical education and training

10 Standard Statement on CPD / Accreditation / Appraisal

Evidence of annual CPD should be documented and presented at annual appraisals (Auditable Standard 97%)

10.1 There is an obligation for all clinicians to maintain competence in their clinical practice, as per professional regulatory bodies.

10.2 All health professionals involved in vasectomy services must ensure adequate CPD is undertaken each year to be presented at annual appraisals.

10.3 It is recommended that a peer review (by an experienced practitioner operating in a similar clinical environment) of a vasectomy surgeon's clinical practice including a DOPS (Direct Observation of Procedures) is carried out at least once every 5 years.

10.4 Annual appraisals should include the appraiser reviewing the vasectomy surgeon's ongoing competence to continue to practice in this specialist field.

10.5 Membership of an accredited representative body such as the FSRH / ASPC is recommended.

11 Standard Statement on Feedback / Audit

A register of post-operative complications should be maintained by the Provider along with benchmarking against peers. (Auditable standard 97%)

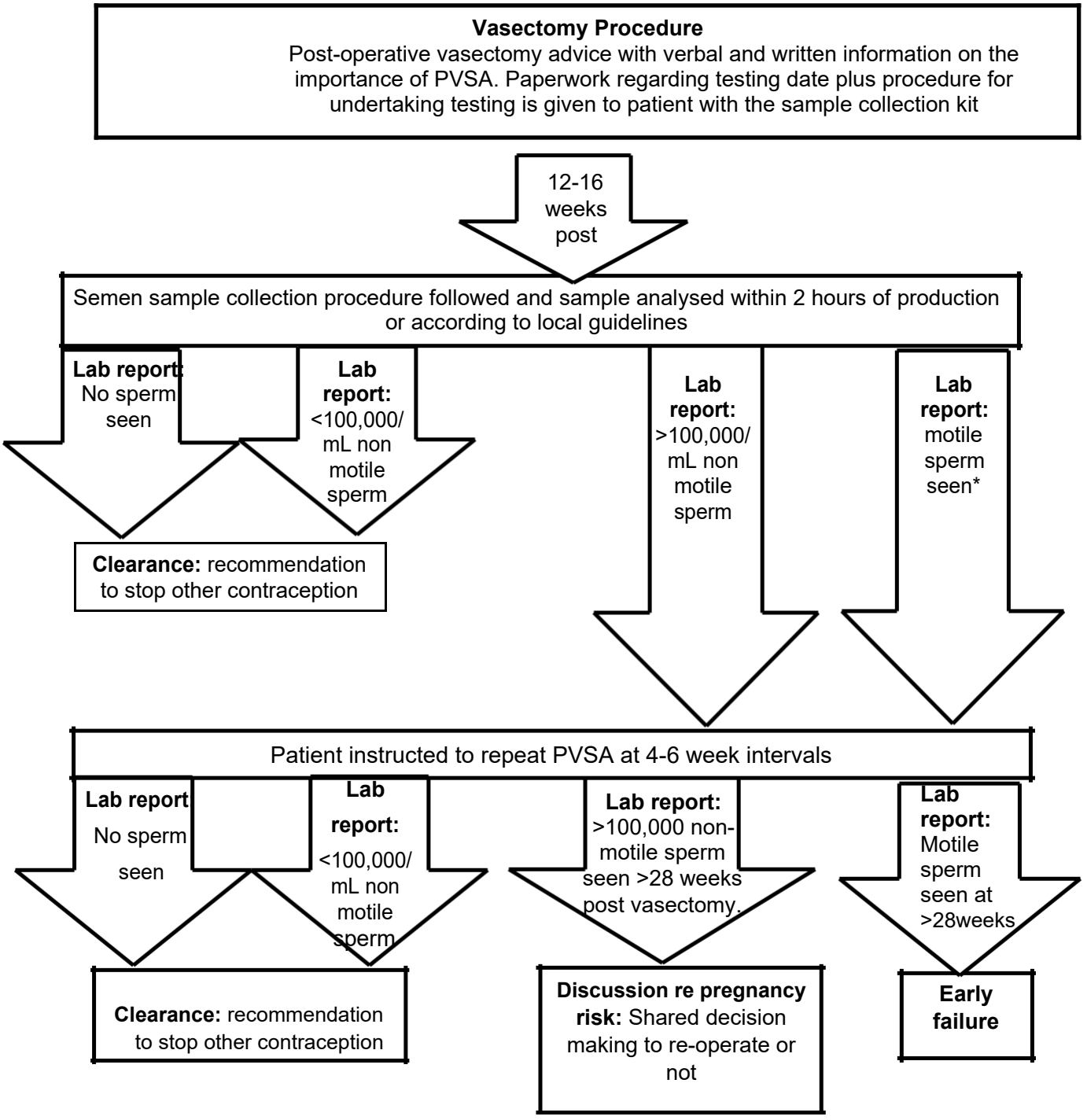
11.1 Vasectomy surgeons should consider utilising the vasectomy audit tools produced by the ASPC. This includes two standardised patient questionnaires for MIV. The first questionnaire is undertaken immediately following the vasectomy and a second questionnaire one or more months later (to capture early complications). These can be accessed online. The ASPC complies an annual summary of its members who contribute their audit results which allows service providers to compare their results with their peers (See Annex 6 and 7).

11.2 A register of failed vasectomies should be maintained by the vasectomy surgeon.

11.3 A register of post-operative complications should be maintained by the vasectomy surgeon.

Annex 1

Clinical pathway for fresh post-vasectomy semen analysis (PVSA) submission and interpretation



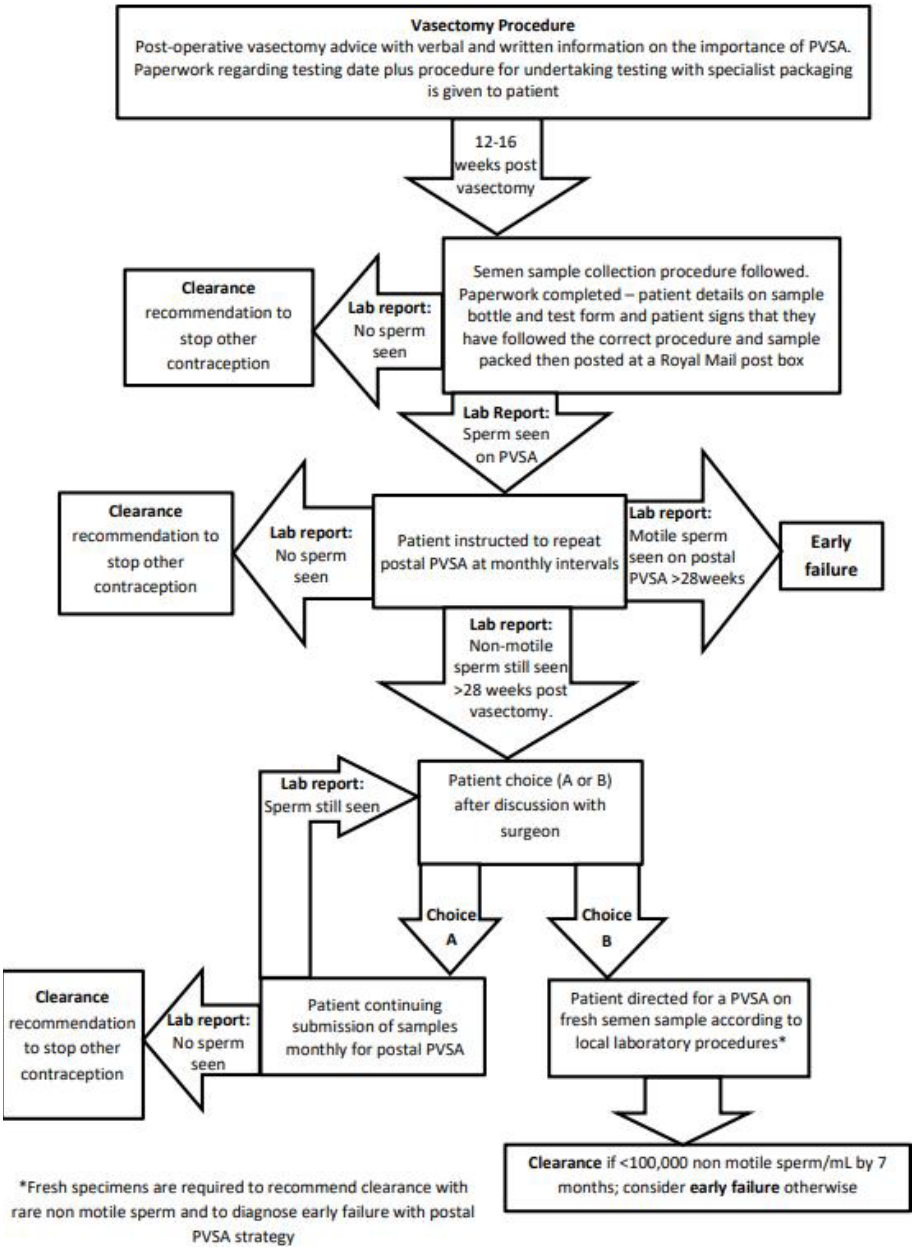
*If motile sperm numbers are low early recanalization is possible and may resolve spontaneously. However higher motile sperm counts are less likely to resolve.[1, 2]

[1]Labrecque M, St-Hilaire K, Turcot L. Delayed vasectomy success in men with a first postvasectomy semen analysis showing motile sperm. Fertility & Sterility 2005; 5: 1435-41

[2]Sokal D, Irsula B, Hays M *et al*. Vasectomy by ligation and excision, with or without fascial interposition: a randomized controlled trial. BMC Med 2004; 2 :6

Annex 2

Current clinical pathway suggested by the Association of Surgeons in Primary Care of United Kingdom for postal post-vasectomy semen analysis (PVSA) submission and interpretation



Annex 3

Peer review and re-accreditation

Minimally Invasive Vasectomy

Peer review and re-accreditation

Surgeon:
Reviewer:

Date:
Location:

Patient 1
Points of note from history, counselling and surgery:

Patient 2
Points of note from history, counselling and surgery:

Patient 3
Points of note from history, counselling and surgery:

Overall assessment:

Surgeon to sign, print name and date:
Reviewer to sign, print name and date:

Minimally Invasive Vasectomy

Peer review and re-accreditation

Date of review
Name of vasectomy surgeon:
Name of reviewer:

	Satisfactory	Comments
1. Preoperative information including processes and booking.		
2. Selection of patients		
3. Counselling on the day		
4. Record keeping		
5. Standard of operating room:		
a. Infection control		
b. Cleanliness		
6. Emergency procedures		
a. Drug box		
b. Oxygen		
c. Resuscitation		
d. BLS and defibrillator certificate		
e. Defibrillator		
7. Equipment and sterilisation procedures		
8. Nurse or HCA assistance		
9. Handwashing		
10. Sterile technique		
11. Rapport		
12. Operative procedure		
a. Overall Competence		
b. Anaesthetic technique		
c. Haemostasis		
d. Dressings		
13. Records of surgery		
14. Postoperative arrangements		
a. Information sheets		
b. Contact numbers		
15. Audit and results		
16. Questionnaires (PROM) and results		
17. Peer support		

Annex 4

Special considerations for patients with partners over 40

Special considerations if your partner is over 40

It is accepted that a woman can abandon the need for contraception if she is:

over 55, or

is 50 and has not had a period for 1 year, or

women who are between 40 and 50 and have not had a period for 2 full years.

When thinking about this bear in mind that the vasectomy does not work immediately and there is at least a 4 month wait until your first test.

If your partner is in her 40s or above you should also consider the menopause in your decision making. If your partner is nearing the age when her mother / sisters / aunties went through the menopause or if your partner already has menopausal symptoms (reduced frequency of periods, hot flushes, etc) it may be that the vasectomy will not be needed for very long and thus you might consider that risks of the procedure may outweigh any benefit.

You should also consider that some women experience very troublesome periods (heavy, clots, frequent, irregular) during the perimenopause and a very good way of managing them is to have a hormone progestogen-releasing coil inserted.

Additionally if your partner were to consider HRT (hormone replacement therapy to control menopausal symptoms) the safest way of taking the HRT is to have the oestrogen (tablet or patch) but with a progesterone releasing coil (to prevent periods, protect the uterus and reduce the risk of cancer; otherwise combined preparations would need to be prescribed cyclically resulting in the return of regular periods) and this would not only help with menopausal symptoms but would also provide effective contraception – so if your partner thinks she may use HRT now or in the future please discuss your options more fully with your GP or alternatively call us and request a phone consultation with one of our doctors.

Annex 5

Vasectomy and Younger Men

Special Message for Young Men with Fewer than Two Children

If you are less than 30 years old and you have had fewer than 2 children, especially if you are single (whatever your age), please consider the following points before having a vasectomy:

1. **You may regret it.** Men who have vasectomies when they are in their 20's, especially if they have had fewer than two children, are the ones most likely (1 in 7 risk) to seek vasectomy reversal at a later date. They may regret their vasectomy decision particularly if reversal is not successful.
2. **You may change.** Many men who think they will never want children when they are in their early 20's are delighted with fatherhood when they are in their 30's. You may be totally convinced now that you will never want children, but people change and you may have a much different outlook 10 years from now.
3. **Women change.** Similarly, women who have no desire for children when they are in their early 20's may have a much stronger desire when they are in their 30's and when many of their friends are having children of their own.
4. **Relationships end.** Since about 42% of UK marriages end in divorce (10% of civil partnerships 'divorcing'), you may not be with the same partner ten years from now and a new partner may have a much stronger desire for children than your present partner does. So just because your present partner claims that she will never want children, her tune may change or she may not even be your partner 10 years from now.
5. **Vasectomy should be considered a permanent and non-reversible procedure** because vasectomy reversals are not always successful. So before having a vasectomy, be aware of all of the other options and that reversal is expensive and not available on the NHS.
6. **Young men may wish to consider sperm storage**. It is well worth the investment, (typically £300 for first sample, £150 subsequent samples, then £300 annually thereafter) but do bear in mind that there is quite a cost implication involved in using the sperm to create a pregnancy subsequently.

Annex 6

ASPC VASECTOMY OPERATION DAY QUESTIONNAIRE 2023-24

ASPC VASECTOMY OPERATION DAY QUESTIONNAIRE 2023-24

1. Did you experience any problems booking your vasectomy appointment? (please circle) **YES** **NO**

If Yes, please tell us why:

2. How good was the information leaflet sent to you prior to your appointment to prepare you for today's operation? (Please circle)

Very Good **Fairly Good** **OK** **Fairly Poor** **Poor**

If you have circled ***Fairly Poor*** or ***Poor*** could you explain why please?

3. How useful did you find the consultation with the Doctor/Nurse before the operation? (Please circle)

Very Useful **Fairly Useful** **OK** **Poor** **Useless** **Not Applicable**

4. Did you feel comfortable having this procedure done at this surgery? (Please circle)

Completely at ease **Very Comfortable** **OK** **Uncomfortable** **Very Uncomfortable**

5. How do you rate the theatre, premises and facilities available here for todays operation? (Please circle)

Excellent **Very Good** **Good** **Adequate** **Poor**

6. How did you rate the Doctor's manner and communication during the operation? (Please circle)

Excellent **Very Good** **Good** **Fair** **Poor**

7. How did you rate the Assistant (s) during your appointment with us? (please circle)

Excellent **Very Good** **Good** **Fair** **Poor**

8. How would you describe the level of pain you felt during the initial injection(s) for the operation? (Please circle)

No Pain **Some Discomfort** **Slightly Painful** **Painful** **Very Painful**

9. How would you describe the level of pain you felt for the rest of the operation? (Please circle)

No Pain **Some Discomfort** **Slightly Painful** **Painful** **Very Painful**

10. At which location did you have your operation today? (Please circle)

Surgery A **Surgery B** **Surgery C**

11. Which Doctor operated on you today? (Please circle)

Dr A **Dr B** **Dr C** **Another Doctor Under Supervision?** **Unsure**

12. Thinking about the service we have provided, overall, how was your experience of our service? (Please circle)

Very Good **Good** **Neither Good nor Bad** **Poor** **Very Poor**

12a. Please tell us about anything that we could have done better

Feel free to provide any further comments on the questions above or compliments/suggestions regarding your Vasectomy & our Service

ASPC GJJ Feb23

Annex 7

ASPC VASECTOMY POST-OPERATION QUESTIONNAIRE 2023-24

ASPC VASECTOMY POST-OPERATION QUESTIONNAIRE 2023-24

Whilst you can undertake this questionnaire anonymously it would greatly help our records if you could give us your details. This allows us to track your recovery post vasectomy with how your operation went, and will also enable us to follow you up in respect to any issues you might highlight. Thank you

Your Name: **Your Email Address:**

Date of Vasectomy (roughly):

1. How would you describe the pain you felt after your Vasectomy? (please circle)

No Pain **Some Discomfort** **Slightly Painful** **Painful** **Very Painful**


2. Are you still experiencing any PAIN following your Vasectomy? **YES** **NO**

Your Surgeon may want to contact you regarding any ongoing pain you may still have, please leave your contact details below if not given above.

3a. Following your Vasectomy did you have to seek any medical advice (urgent or routine) for any reason? **YES** **NO**

If YES, who did you see? (please circle / choose ALL that apply)

i. Vasectomy Surgeon
ii. GP
iii. Out Of Hours
iv. A+E / Casualty
v. Hospital Consultant (as in an outpatients appointment)

3b. Did you require to be admitted overnight to hospital due to a medical issue relating to your vasectomy **YES** **NO**

Please explain why you had to seek medical advice or need admitting to hospital and what was the outcome?

(If not enough space in this box, please feel free to expand your answer on the back of this questionnaire)

4. Did you require any ANTIBIOTICS resulting from the Vasectomy? **YES** **NO**

If YES: Can you tell us why you were given Antibiotics (if you haven't told us already)?

Roughly how many days after the procedure were antibiotics prescribed?

Who prescribed the antibiotics? (Please circle) **Vasectomy Surgeon** **GP** **Other**

5a. After the operation did you experience a PAINFUL SWELLING in the scrotal sac that resulted in EITHER of your testicles (balls) appearing to become double their original size? **YES** **NO**

If **YES** please answer: **5b. How big would you describe the swelling?** (Just the swelling and not the size of the whole ball sack)

Double your original testicle size | Cricket ball size or over | Somewhere between the 2 choices given

6. How good was the information in the Post-Op Advice leaflet in preparing you for any post operative issues?

Very Good | Fairly Good | OK | Fairly Poor | Poor | Never Given One

Please feel free to add how do you think the Post-Op Leaflet could be improved in the final comment box of this questionnaire

7a. Thinking about the service we have provided, overall, how was your experience of our service? (Please circle)

Very Good | Good | Neither Good nor Bad | Poor | Very Poor

7b. Please tell us about anything that we could have done better

8. Which Doctor operated on you? (please circle)

Dr A | Dr B | Another Doctor under supervision | Unsure

9. At which SURGERY did you have your operation? (please circle)

Location A | Location B | Location C | Can't remember

Finally, please feel free to provide any further comments on the questions above or any final thoughts on your experience

ASPC GJJ March 23