

Reversal of Sterilization in the Female

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The myth that the operation of sterilization in the female is irreversible dies hard. A certain proportion of patients undergoing sterilization may afterwards regret having had the operation, due to the death of children, of divorce or death of a husband and subsequent remarriage. In this article the author describes the surgical procedures that may be used to reopen the Fallopian tubes and the known incidence of pregnancy after tube-uterine implantation.

THERE is no doubt that the number of sterilization is increasing. In 1964 four operations, apart from those done as a routine at the third Caesarean section, were performed at the main hospital of this group compared with 30 done in 1968. The rethinking necessary just before and after the Abortion Act 1967 has aided this liberalization of the attitude of gynaecologists to unlimited child-bearing. Contraception is still not infallible and not all patients are happy with any of the methods, including the pill.

Consequences

The consequence of this increase is twofold. First, the age when sterilization is performed is falling and secondly, the psychological effect on the mother of sterilization is becoming more widely recognised. It is probable that a certain percentage of these patients may bitterly regret the operation which at the time it was performed appeared the logical and sensible course. Guilt feelings may emerge, not necessarily only in Roman Catholic patients, as to the wisdom of sterilization. Divorce from or death of a husband may in time be followed by remarriage and the thought of a further child by this marriage. Death of a child may reawaken the desire for further children.

The myth of the operation being irreversible dies hard. Sterilization may be performed by a number of methods. If it is done by complete removal of both tubes the outlook is indeed grim. A number of these cases have been treated by implantation of the ovary with an intact blood supply into the cavity of the uterus. Pregnancies have been recorded following this procedure but the likelihood is small indeed. However, the minority of sterilizations re-performed by total ablation of the tubes. The more usual methods involve either coagulation and division of the isthmus by laparoscopy removal of a wedge of uterus with a portion of the isthmus, or tying and removal of a loop of the midsection of the tube. In all of these methods a fair length of the tube is left and the fimbriated end of the tube is included. It is perfectly healthy except that it is shortened.

Tube-uterine Implantation

The knowledge that blockage of the Fallopian tube at its uterine end is no bar to conception has been performed for many years. The essentials of this operation, known as tube-uterine implantation, consists of reopening the tube beyond the obstruction, making a passage for the tube through the uterine wall either by reaming a hole or

opening the uterus, stitching the lining of the tube to the endometrium and fixing the muscle layer of the tube to the uterus. Many operators use a polythene rod through the Fallopian tube to keep the lumen open. This polythene rod may be passed from one tube through the uterine cavity to the opposite tube leaving a loop in the uterine cavity, or two rods may be used, passing each down through the uterine cavity and fixing them to the cervix or vagina. The rod or rods are removed either weeks or month later per vaginam.

Given enough tube, including the fimbriated end, the same operation is ideal for reversing the operation of sterilization. The added advantage is that in these cases the tubes are known to be healthy and the patient known to be fertile. In many cases these patients are very fertile, this being the original reason for the sterilization. An alternative operation is also possible in these patients and may be the better operation in certain cases. If it is found at operation that an insufficient length of tube is attached to the fimbria it is better then to do an end-to-end anastomosis of the fimbrial end to the stump of tube left at the uterine end. Again, polythene tubing may be used to splint the Fallopian tube until healing is complete and removed later per vaginam. This is a more physiological operation and does not leave a potentially weak area in the uterus.

Advice to Patients

Confronted with the problem of the previously sterilized patient, who now wishes for a further child for whatever reason, the gynaecologist is asked to give her his advice. The first point, of course, is to perform a complete seminal examination of her husband. If this is satisfactory, the couple will need to know the risk of the operation itself, the percentage possibility of pregnancy, the risks of abortion or ectopic pregnancy, and the dangers of a malformed child.

The answer to all these questions have been difficult to find as only individual series of the tube-uterine implantation operations have been

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