Placename CCG

Policies for the Commissioning of Healthcare

Policy for Sterilisation Reversal in Males and Females

	Introduction
	This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
1	**Policy**
1.1	The CCG considers that sterilisation reversal does not accord with the Principles of Appropriateness (i.e. the CCG considers that other services competing for the same CCG resource more clearly have a purpose of preserving life or of preventing grave health consequences) and therefore the CCG will commission this service only when exceptionality has been demonstrated in accordance with Section 8 below.
2	**Scope and definitions**
2.1	This policy is based on the CCGs Statement of Principles for Commissioning of Healthcare (19 January 2016).
2.2	Reversal of sterilisation is a surgical procedure involving the reconstruction of the vas deferens in males (vasovasostomy, vasoepididymostomy) and the reconstruction of the fallopian tubes or removal of clips from the fallopian tubes in females with the main aim of restoring fertility after a voluntary surgical sterilisation. In some instances, vasectomy reversal is carried out in males to relieve post-vasectomy pain after failure of conservative management,[1] while removal of clips may be done to relieve post tubal ligation syndrome (PTLS) in females. [i]
2.3	The scope of this policy includes requests for sterilisation reversal following voluntary sterilisation as a permanent contraceptive method, in people of either gender.
2.4	The CCG recognises that a patient may have certain features, such as: • Having sterility after voluntary sterilisation as a permanent method of contraception • Wishing to have a service provided for restoring fertility due to non-medical reasons e.g. loss of an only child, being in a new relationship. • Being advised that they are clinically suitable for reversal of sterilisation, and

[i] Information from clinical consultation on the draft policy.

	• Be distressed by their sterility, post-vasectomy pain or post tubal ligation syndrome, and by the fact that that they may not meet the criteria specified in this commissioning policy. Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.

2.5	For the purpose of this policy, the CCG defines males and female sterilisation reversal as any surgical procedure in people who have had voluntary sterilisation as a permanent contraception method to restore patency of the vas deferens or the fallopian tubes, with the aim of restoring fertility, or managing post-vasectomy pain or post tubal ligation syndrome.
	
	The relevant OPCS codes associated with the procedures are listed below:
	
	Female sterilisation reversal
	• Q29: Open reversal of female sterilisation
	  ○ Q29.1: Re-anastomosis of fallopian tube NEC
	  ○ Q29.2: Open removal of clip from fallopian tube NEC
	  ○ Q29.8: Other specified open reversal of female sterilisation
	  ○ Q29.9: Unspecified open reversal of female sterilisation
	• Q37: Endoscopic reversal of female sterilisation
	  ○ Q37.1: Endoscopic removal of clip from fallopian tube
	  ○ Q37.8: Other specified endoscopic reversal of female sterilisation
	  ○ Q37.9: Unspecified endoscopic reversal of female sterilisation
	
	Reversal of male sterilization
	• N18.1: Reversal of bilateral Vasectomy

3	**Appropriate Healthcare**
3.1	The purpose of sterilisation reversal is normally to restore fertility after voluntary sterilisation in either gender.
3.2	This policy relies on the criterion of appropriateness in that the CCG considers that sterility following voluntary sterilisation performed as a permanent contraception method is not a medical condition and treatment for it does not otherwise accord with the criteria for appropriateness in the Statement of Principles.
4	**Effective Healthcare**
4.1	This policy relies on the criterion of effectiveness in relation to commissioning sterilisation reversal for the management of post-vasectomy pain or post tubal ligation syndrome as the CCG considers there is insufficient evidence that sterilisation reversal for these purposes can achieve the intended outcomes. [2, 3, 4, 5, 6]
5	**Cost Effectiveness**

5.1	The CCG does not call into question the cost-effectiveness of sterilisation reversal and therefore this policy does not rely on the Principle of Cost-Effectiveness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be Cost Effective in this patient before confirming a decision to provide funding.
6	**Ethics**
6.1	The CCG does not call into question the ethics of sterilisation reversal and therefore this policy does not rely on the Principle of Ethics. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to raise ethical concerns in this patient before confirming a decision to provide funding.
7	**Affordability**
7.1	The CCG does not call into question the affordability of sterilisation reversal and therefore this policy does not rely on the Principle of Affordability. Nevertheless if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be affordable in this patient before confirming a decision to provide funding.
8	**Exceptions**
8.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.
8.2	Inadequate or improper counselling will not be considered as a basis for exceptionality. The Faculty of Sexual & Reproductive Healthcare (2014) and the Royal College of Obstetricians and Gynaecologists (2016) [7] recommend counselling and advice on sterilisation procedures should be provided to women and men and should include information on the advantages, disadvantages and relative failure rates of each method. The Royal College of Obstetricians and Gynaecologists (2016) further emphasised it is crucial the permanent nature of the procedure is reiterated to patients intending to undergo sterilisation and should include ascertainment of patients' wishes not to have any more children in the future. In the event of inconsistency, this policy will take precedence over any non-mandatory NICE guidance in driving decisions of this CCG. A circumstance in which a patient satisfies NICE guidance but does not satisfy the criteria in this policy does not amount to exceptionality.
9	**Force**

9.1	This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance relating to this intervention, or to alternative treatments for the same condition.
9.2	In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then: • If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory. • If the new NICE guidance does not have mandatory status, then the CCG will aspire to review and update this policy accordingly. However, until the CCG adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this CCG are concerned.

Date of adoption
Date for review

10 References

1. [1] Smith-Harrison L. I., Smith R.P. Vasectomy reversal for post-vasectomy pain syndrome. Transl Androl Urol. 2017; 6(Suppl 1): S10–S13. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5503916/

2. [2] Smith-Harrison L. I., Smith R.P. Vasectomy reversal for post-vasectomy pain syndrome. Transl Androl Urol. 2017; 6(Suppl 1): S10–S13. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5503916/

3. [3] Faculty of Sexual & Reproductive Healthcare (2014). Male and Female Sterilisation. https://www.fsrh.org/documents/cec-ceu-guidance-sterilisation-cpd-sep-2014/

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5. [5] Rulin MC, Turner JH, Dunworth R, Thompson DS. Post-tubal sterilization syndrome--a misnomer. Am J Obstet Gynecol. 1985; 1;151(1):13-9. https://www.ncbi.nlm.nih.gov/pubmed/3966496

6. [6] Shobeiri MJ, AtashKhoii S. The risk of menstrual abnormalities after tubal sterilization: a case control study. BMC Women's Health. 2005 5:5. https://bmcwomenshealth.biomedcentral.com/articles/10.1186/1472-6874-5-5

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