General Commissioning Policy

Treatment	Reversal of Female or Male Sterilisation
Background	From April 2013 NHS England took over responsibility for commissioning activity in primary care, where initial conservative treatment takes place. NHS Hull Clinical Commissioning Group (CCG) is responsible for commissioning activity in secondary care, and this policy sets out the referral criteria for reversal of female or male sterilisation. This surgical procedure is not routinely commissioned by NHS Hull CCG and such requests are thus considered via the Individual Funding Request (IFR) process.
Commissioning position	NHS Hull CCG does not routinely commission the reversal of male or female sterilisation, except in the most exceptional of circumstances and after agreement of the IFR Panel. It is recommended that before proceeding with female sterilisation by tubal ligation or male sterilisation by vasectomy, thorough counselling be given to the patient (and partner) so they have a clear understanding that these interventions are provided by the NHS as irreversible and local NHS policy is not to fund reversal of these procedures. (Ref 1) It is recommended that sterilisation or vasectomies are not normally performed on those under 30 (Ref 2), those who appear to be in unstable or conflicting relationships and that sterilisation is not performed during caesarean section. Exceptions to these can be assessed during pre-operative counselling. Evidence suggests that reversal of female sterilisation is a safe and technically straightforward option for restoring fertility after tubal ligation (Ref 3). However, it should be made clear to patients at referral and prior to treatment that female sterilisation is provided by the NHS as an irreversible procedure. Male sterilisation is also provided by the NHS as an irreversible procedure. This should be made clear to patients at referral and prior to treatment. Thus, requests for reversal of sterilisation will only be considered in exceptional circumstances. For example, factors that will be considered by the IFR Panel might include the following: • No living children from the current relationship • Death of a spouse • Psychiatric illness at the time of sterilisation • Sterilisation at a very young age (<24 years of age) • Current age of the patient (females must be under 35) and partner • Sterilisation procedure was performed by the NHS • In men, a clear clinical rationale such as severe post vasectomy pain syndrome (Ref 4)

Notes

1. This Policy will be reviewed in the light of new evidence, or guidance from NICE.
2. General Commissioning Policies are agreed by the Planning and Commissioning Committee on behalf of NHS Hull CCG.

	• The likely outcome in terms of fertility (for males this will include consideration of the time since vasectomy and for females reversal will not be undertaken in women with a poor prognosis as indicated by medical history or laparoscopic examination); • Previous requests or attempts at reversal • Advice on the medical feasibility of the procedure from a secondary care consultant.
Effective from	July 2014 (policy reworded for clarity)
Summary of evidence / rationale	The pregnancy rate after vasectomy reversal with obstructive intervals of 10 -15, 16 -19, and 20 or more years was 40%, 36%, and 27%, respectively. The overall ongoing/delivered rate was 35%. The ongoing/delivered rates equalled the pregnancy rates, except in the 16 -19-year obstructive interval group, for which the ongoing/delivered rate was 27%. (Ref 6) Even after prolonged obstructive intervals, vasectomy reversal can offer better or comparable success rates to ICSI (Intracytoplasmic Sperm Injection), until a threshold obstructive interval of 15-20 years at which ICSI surpasses vasectomy reversal. Depending on their wishes, couples who have an obstructive interval that exceeds this threshold may be better served by ICSI.
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References:

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