

APPENDIX

Dr A.K. Sharma's paper on vasectomy as read at the Family Planning Symposium at the 4th All Nepal Medical Conference, Birgunj in Feb, 1969 is given below. This has been reported in the report of the seminar held by Family Planning and MCH in this issue and also in the discussion on vasectomy reported above:-

SURGICAL ASPECT OF FAMILY PLANNING

The family planning was known to the people even in ancient days. The people to plan their family because there was scarcity of food and it was difficult to make available to everybody. In those days, men used to control the number of their family by crude methods eg infanticides and abortions. With the time, the older order has changed place to newer and better methods of planning the family. The various methods of contraceptives have following difficulties:

- (a) The method is not properly understood or applied,
- (b) Lack of privacy in our homes,
- (c) Carelessness are quite frequent,
- (d) condoms are not freely available,
- (e) pills are costly for the general mass, may not suit, &
- (f) I.U.D. are not very popular.

Hence, we recommend surgical procedure, which is the safest and the best method of stopping reproduction. It must be clear that the procedures are permanent ones and results of recanalisation cannot be guaranteed.

While reduction in birth rate is beneficial, illegal abortions are particularly threat to health of the mother. Induced abortions under good medical care is quite safe. Our law allows induced abortions only when the maternal life saving is essential. In the absence of law, a woman who is determined to end the pregnancy must turn to illegal source for help. Hence, I request the Family Planning bodies to take up the subject with the judicial people and try to legalise abortion: so that many valuable life could be saved.

The following surgical procedures are available for Planning the Family.

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| 1. VASECTOMY. | 3. RE UNION OF VAS DEFERENS. |
| 2. TUBE LIGATION. | 4. SALP INGESTOMY or SALPINGOPLASTY |
| 5. ABORTION. | |

The vasectomy has been the most popular single method of reducing the birth rate. It can be performed within ten minutes. My humble request to my colleagues about the operations are the followings;

- i) To perform the operation at the root of the scrotum—in the straight part of the deferens.
- ii) To excise only small portion of the vas.

- iii) To crush and ligate the two ends separately, and to bring the two knots nearer to each other

The operation will be successful once the vas has been interrupted no matter which technique has been used. The above method will facilitate the re-union if it be necessary and reduce the incidence of dragging pain.

FAILED VASECTOMY

By true failed vasectomy I mean presence of spermatozoa in semen after the lapse of unsafe period (3-6 months after operation or TEN ejaculations.) Out of about 5000 cases operated, only one case had established recanalisation of the vas through the knot. Four cases of failure were due to ligation of anything else than vas (done by one single compounder in the valley.). The causes of failed vasectomy are detailed below.

1. Pregnancy during unsafe period.
2. True recanalisation
 - a) Through the knot. 1 case,
 - b) Infection of the suture, material, bag formation.
3. Ligation of the wrong structure. - 4 cases.
4. Presence of accessory vas.
5. Helped by the neighbours.

RE UNION OF VAS DEFERENS

During the last 5 years that I have started reuniting the vas deferens 41 cases have been operated. The number of cases are increasing every year.

The indications for the re union of the vas.

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| 1. Loss of children, especially the son. | - | - | 23 cases. |
| 2. Re-reunion (ANOTHER marriage) | - | - | 6 cases. |
| 3. Accidental vasectomy, during operation for hydrocoele, hernia, filaria scrotum etc. | - | - | 4 cases. |
| 4. Injury of scrotum involving the vas. | - | - | 1 case. |
| 5. Psychological change after vasectomy. | - | - | 1 case. |
| 6. Wrong motivation- temporary vasectomy | - | - | 3 cases. |
| 7. Infection of the scrotum involving the vas. | - | - | 1 case. |
| 8. Wrong operation done. | - | - | 2 cases. |
| | | TOTAL | 41 cases. |

Technique of recanalisation. Under local anaesthesia, a vertical incision is made over the scrotum. The vas deferens is mobilised. The ends are divided with sharp cutting knife and the knot is removed. Now the patency of the vas is confirmed. There should be free flow of white fluid from the testicular end of the vas. This fluid, if examined under microscope will reveal the presence of spermatozoa. A silk worm gut is passed in the lumen of both the proximal and the distal tubes, About 5 ml. of sterile normal saline is injected into the lumen of the prostatic end of the vas, to flush out the vas deferens, seminal-vesicle and common ejaculatory duct. Once the patency of the vas is confirmed, end to end anasto-

mosis is performed. A piece of catgut put in the lumen as a splint is very helpful. I use atraumatic 00 chromised catgut with round bodied straight needle. The needle is introduced through the fibromuscular coat of the vas, brought out through the lumen, threaded through the lumen of the distal tube and brought out through its fibromuscular coat. A knot is tied so that the two ends are approximated. A few more stitches of 00000 atraumatic silk thread with cutting curved needle are put over the fibromuscular wall of the vas deferens. The same procedure is repeated over the opposite side. The wound is closed with interrupted silk thread. The patient receives 35 mgm. of testosterone every week (8 SUCH) by parenteral route to stimulate spermatogenesis.

RESULTS

In 35 cases where the vasectomy was reversed, the result was excellent. Every one started passing spermatozoa in the semen in two months time. The result of reunion in cases of secondary sterility due to blockage of the vas has been disappointing. In these cases the patency of the vas could not be confirmed. The result of reunion after accidental injury of the vas cannot be said; because the accident is usually unilateral (and I strongly feel that the two testicles are luxury: one is enough for reproduction.).

In conclusion I don't want to be too optimistic about the result of recanalisation of vas. Fatke, the authority in the subject quoted a success rate of just over 40%. One could forecast the prognosis of the case at the time of operation. If the two ends are patent, the result of the union is going to be successful, no matter how the anastomosis is done. To the people who come for vasectomy I will certainly tell that the procedure is a permanent one and never temporary.

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