

Vasectomy Reversal Consultation 101



Dr. McHugh offers free of charge a phone or office consultation to any couple considering a vasectomy reversal. A pre-operative visit by phone consultation for the male with no significant health issues is an acceptable and safe option for our out-of-town patients. The following outlines the reversal process at the Northeast Georgia Urological Surgery Center.

- The procedure will be performed by Dr. McHugh with general anesthesia provided by a board-certified anesthesiologist in our accredited urological surgery center.
- The patient will be examined by both Dr. McHugh and the anesthesiologist prior to the procedure.
- If a patient is over 50 or has other medical issues, we may request that the patient obtain a pre-operative clearance and baseline lab evaluation by his family doctor.
- The procedure will last approximately two hours.
- There will be two $\frac{3}{4}$ inch incisions at upper aspect of the scrotum bilaterally. Absorbable sutures will be used and will dissolve in approximately two weeks.
- A Zeiss operating microscope and microscopic suture will be utilized for the procedure.
- The method used for the procedure is a modified two-layer closure with the usual total number of sutures being 12 -14 on each side. These are non-absorbable sutures.
- The vasectomy site is delineated, bypassed and the testicular end of the vas and the body end will be freshened up, examined under the operating microscope to be sure they are pristine, and then the microscopic anastomosis will begin.
- Microscopic instruments, fashioned for this procedure, will be used.
- The reversal will be watertight and tension free assuring the best chance of a patent vas deferens and successful presence of sperm in the ejaculate.

- The fluid from the testicular end of both of the vas deferens will be examined under a microscope. The patient and wife will be informed of the findings; the presence or absence of sperm, sperm parts and the character of the fluid is a predictive factor of success.
- The potential need for a vasoepididymostomy is more likely if the patient had his vasectomy over ten years prior to the procedure.
- If there is no fluid or there is a paste-like fluid in the testicular side of vas the likelihood of an obstruction before the vasectomy site is considered. The epididymis is then evaluated. A intussusception vasoepididymostomy will be performed if an isolated area of obstruction is noted with proximal dilation of the epididymal tubules.
- The patient leaves our center with ice over the incision which should remain for two hours.
- The small incisions should have Neosporin placed on them daily until healing and taking a shower the next day is okay if care is taken not to let the water hit the incision site directly.
- After the surgery, the patient should refrain from sexual activity for three weeks as well as strenuous activity. If the procedure is performed on a Thursday, for instance, he should be able to return to work on a Monday if it is a non-strenuous job. The more time taken off from work to be off your feet the less likely there is for swelling and bruising. Bruising and swelling to some degree is expected due to the length of the procedure and should not be a cause for alarm.
- Use of exercise compression shorts instead of a "jock strap" provides the elevation and pressure to the testicles to encourage the healing of the vas repair site and decreases bruising and swelling.
- If a patient desires to evaluate a semen specimen for sperm post-reversal we recommend waiting 4-6 months to allow the testicles to readjust to the now unobstructed vas deferens.
- We offer complimentary hotel accommodations for the family who is out of town and prefers to arrive the night before or stay the night after the procedure.
- The success rate of a vasovasostomy is multi-factorial. The reversal has to be patent, the length of time between the procedure and the vasectomy is an important factor, with the shorter time period having the best results. Other factors to consider include the normal impediments of pregnancy that occur between any couple in normal circumstances.
- Patency means that after the procedure the patient has sperm in the ejaculate. Achieving pregnancy is dependent on the quality of the sperm and factors related to the female. Because of this, there is a difference between seeing sperm in the ejaculate after the procedure and achieving pregnancy. For instance at 5 years after a vasectomy, following a vasovasostomy the chance of patency is approximately 75% where as achieving pregnancy might be 60%. These numbers vary pending on the various studies. Understanding patency vs. pregnancy and the length of time between the vasectomy and the vasovasostomy is important.
- The fee charged is all inclusive except for the prescription given post op for an antibiotic and pain medications.
- We provide the family member the prescription which can be filled while we perform the procedure. We will contact the family member when we have completed the first side of the procedure and are beginning the second side.

- Local anesthesia is placed in the incision sites to limit post operative pain on the trip home and the anesthesiologist takes measures as well by providing intravenous medications for pain control and the prevention of post anesthesia nausea.
- Our surgery center nurse manager will call post operatively to check on you and answer or handle any issue that may arise.
- Finally, we'd appreciate a call when pregnancy is achieved and would really like a picture of the baby.

Finally on behalf of the Northeast Georgia Urological Ambulatory Surgery Center staff and Dr. McHugh, we look forward to working with you and together achieving the precious new addition to your family.



Vasectomy Reversal Success Rate

Less than 3 years- Patency 97% Pregnancy 76%

3-8 years - Patency 88% Pregnancy 53%

9-14 years - Patency 79% Pregnancy 44%

Greater than 15 years - Patency 71% Pregnancy 30%

Belker AM, et al. Results of 1,469 microsurgical vasectomy reversals by the Vasovasostomy Study Group. Journal of Urology 1991; 145(3):505-11.