TUBAL REVERSAL

Patient wishing additional children after prior tubal sterilization have three options. Option #1 is adoption, option #2 is in vitro fertilization, and option #3 is tubal reversal. These options are presented below.

The conception rate per cycle with in vitro fertilization in many clinics is in 40-50% range for uncomplicated cases such as this patient likely represents. IVF is very costly and typically at least three treatment cycles should be planned for to have a reasonable expectation of achieving pregnancy. Further, additional cycles will be required every time the couple wishes additional pregnancies in the future.

The cost of tubal reversal is also high. Should the patient conceive, she will likely be able to conceive again and therefore with one procedure she can have multiple additional children. However in this strategy, the patient will once again require tubal sterilization or other contraceptive methods once she ceases to wish additional childbearing.

Risks associated with laparotomy and anesthesia are present and apply primarily to tubal reversal although sedation is also required for egg retrieval procedures (with IVF). Risks associated with a surgical component include injury to bowel, urinary tract, intra-abdominal vasculature, development of infection, ileus, and other complications which are too many to discuss. Should the patient conceive after tubal reanastomosis, the likelihood of ectopic gestation is far higher than had tubes never been tied before. The roughly 1 in 10,000 maternal death rate still has a significant contribution from ruptured ectopic pregnancies. Any pregnancy after tubal reversal must be watched carefully for ectopic.

For patients contemplating tubal reversal, it is impossible to assure that there is sufficient proximal and distal tube without additional investigation preoperatively. At least 3-4 cm of proximal and distal tube are necessary for a successful repair. The presence of the fimbria is also a key consideration. Unless pathology report or intra-operative photos are available, one can only surmise that a mid segment tubal interruption was performed.

The potential for a preoperative laparoscopy to assess the pelvis, the length of tube proximal and distal on both sides as well as the health of the fimbria and other intra-abdominal structures is advised. Pre-operative FSH is also advised to assess patient's fecundability—increasing FSH often signals approaching menopause and diminished fertilizability of oocytes.

The male factor must be considered as well. This is essential before contemplating a tubal reversal. History, semananalysis, GC and CT probes are necessary.

The method of tubal reanastomosis is open for debate. One option is laparotomy and microsurgical tubal reanastomosis with microscopic instruments and techniques. This is a time consuming procedure often taking between three and six hours. Another option is laparoscopic tubal re-anastomosis. This is done with three to four 5 to 11 mm incisions in the abdomen. Success rates for either method is approximately 50%, meaning that one woman in two undergoing tubal reversal will likely have a successful live vaginal birth as a consequence.

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Patients are invited to go to WebMD and other lay accessible sources to get additional information. Patients are urged to consider the differential merits of adoption, IVF, and tubal reanastomosis prior to making a definitive decision regarding which modality to go with.

