Sterilization of the woman (laparoscopic sterilization)

A sterilization in the woman is a treatment to prevent pregnancies.

With a sterilization, the gynecologist closes both fallopian tubes or the fallopian tubes are removed. If the fallopian tubes are closed or removed, the sperm cells can no longer reach the egg and you can no longer become pregnant.

A sterilization cannot be reversed, so it is only a good choice if you are sure that you do not want children (anymore). The sterilization is done via keyhole surgery and can be done in three ways.

- Both fallopian tubes are closed. We place clips on the fallopian tubes.
- Both fallopian tubes are removed completely.
- Burning the fallopian tubes.

You will discuss which method of sterilization is done together with your doctor,

Advantages and disadvantages of sterilization

Advantages of a sterilization

- Your contraception is taken care of, you don't have to think about it anymore.
- No more use of hormones, your ovaries make hormones naturally.
- The chance of pregnancy is small.

Disadvantages of sterilization

- You have a chance of a complication of the procedure.
- If you regret it, it is not possible or difficult to have a recovery operation done.
- You need additional insurance, a sterilization is not included in the basic package.

How does the treatment work?

Here you will find all the important information about your treatment

Important information for sterilization

What you need to know to be able to decide whether a sterilization is the desired form of contraception for you

Chance of pregnancy after sterilization

The chance of pregnancy after laparoscopic sterilization depends on the technique used. If the fallopian tubes are closed, 2-5 per 1,000 women become pregnant. Sometimes the clip goes off the fallopian tube, even if it is properly placed. The fallopian tubes can sometimes grow back together and make a passage again.

The chance of pregnancy is greater if part of the fallopian tubes are burned shut, possibly there is a little more chance than when placing a clip. If both fallopian tubes are completely removed, pregnancy is almost impossible.

Regrets after a sterilization?

Women who have a sterilization done, usually know for sure that they do not want to have children (anymore). Yet women and partners sometimes regret it. Usually it is about a desire to have children in a new relationship. About 6% of sterilized women regret it.

Who is more likely to regret?

The younger you are, the more likely you are to have regrets. Furthermore, we know that you also have a greater chance of regret if you are single or if you do not yet have children. We therefore advise you not to make a decision if you are under pressure. Think of relationship problems or problems with a pregnancy, such as a miscarriage or an abortion. Emotions can influence your decision.

Chance of recovery if you have regrets?

Are the fallopian tubes closed during a laparoscopic sterilization and do you still want to have children? Then there is an opportunity to restore the fallopian tubes. Usually this can be done with keyhole surgery. If the operation goes well, you have a 40 to 85% chance of a pregnancy afterwards. You're most likely to have clips. If the fallopian tubes are burned shut, then the chance of a successful operation is smaller. After recovery surgery, you have a higher risk of an ectopic pregnancy (2%).

A recovery operation is expensive and is not reimbursed by the insurance. You can also opt for IVF treatment. The chance of a pregnancy with 3 treatments is on average about 50%. Have the fallopian tubes been removed during the sterilization and do you have a pregnancy wish? Then it is only possible to become pregnant through IVF treatment.

Risks

The following complications or problems may occur with laparoscopic sterilization:

- problems or complications due to anesthesia
- damage to intestines, bladder or blood vessel
- infection
- failure of sterilization

Damage to the intestine, bladder, blood vessel

During the insertion of the instruments, the gynecologist may damage the intestines, bladder or a blood vessel. This happens in less than 1% of women. If necessary, you will have a more extensive abdominal operation. The recovery will then take longer. Sometimes it is only after the operation that it is clear that there is a problem. You will receive advice on when to contact us.

In addition, there may be a slightly increased risk of (after) bleeding if both fallopian tubes are removed. When removing tissue, bleeding may occur.

Failure of sterilization or difficult sterilization

If you have adhesions, sterilization can be difficult. The gynecologist can make an additional opening for a third instrument. Then it usually works. If you are overweight, it can be difficult to insert the instruments. The gynecologist can then make the opening at the navel slightly larger. If that also does not work, the gynecologist can make a small cut just above the pubic hair.

Your gynecologist will ask you before the operation if you are okay with this. If the fallopian tubes are too thick, it is not always possible to place a clip. The gynecologist can often burn the fallopian tubes. The chance that a laparoscopic sterilization ultimately fails, we estimate at less than 1%.

You are more likely to have problems if you:

- Have health problems, this because of the anesthesia.
- Are overweight (BMI higher than 30).
- Have had a fallopian tube infection or peritonitis.
- Had an intestinal operation.

Possible additional consequences of long-term sterilization

- Research has shown that both a sterilization in which the fallopian tubes are closed and a sterilization in which both fallopian tubes are completely removed ensure a lower chance of developing ovarian cancer later in life. This is because the fallopian tubes play a role in the development of ovarian cancer. Ovarian cancer is a serious disease. The protective effect of removing the fallopian tubes is greater than the protective effect of closing the fallopian tubes. On average, 1 in 100 women will develop ovarian cancer in later life. After the fallopian tubes are removed, 1 in 200 women will develop ovarian cancer later in life. This means that if the fallopian tubes are removed, the chance of developing ovarian cancer later in life is halved. After the closure of the fallopian tubes, 1 in 140 women will develop ovarian cancer later in life.

- Because the ovaries and fallopian tubes are close together, there may be a small chance that the functioning of the ovary will be disturbed when the fallopian tubes are removed. As a result, you may be able to get into the transition a little earlier than if you hadn't had the surgery. This does not apply if clips have been placed because no tissue has been removed. The available research so far shows no change in the functioning of the ovaries after the removal of the fallopian tubes. However, insufficient research has been done on the effect on the function of the ovaries after the removal of the fallopian tubes in the long term.

Is the sterilization reimbursed?

A sterilization does not fall within the basic package. Ask your health insurer which additional insurance is sufficient. This differs per insurer, per package and per year. Is the sterilization fully reimbursed? Then this usually does not affect your own risk.

Preparation

How do you prepare?

Not pregnant

Make sure you are not pregnant during the sterilization. Make sure there is no chance that there has just been a fertilization. If you take the pill, finish the strip. If you have an IUD, talk to your gynecologist when you have it removed. Do you use condoms or is there a risk of pregnancy? Then it is best to have the sterilization done in the first week after your period. At least before your ovulation.

It is important that you are properly and safely prepared for the operation. That is why you have an appointment with Anesthesia department some time before your admission to the hospital. Please note! The agreements with the anesthesiology department are important; your operation cannot continue without this appointment.

Surgery is only possible if you are sober. 'Fasting' means that your stomach is empty. This prevents the contents of your stomach from ending up in the trachea and lungs during the operation. This could lead to serious complications.

You should always be sober before surgery, even if you are receiving a regional anaesthetic (e.g. epidural). To ensure that you fast (not eating/drinking), adhere to the following rules:

Up to 6 hours before the time of admission:

- You may eat and drink normally.

From 6 hours before the time of admission:

- You are not allowed to eat anything anymore (not even sweets). You can still chew gum, but you should not swallow it.
- You can still drink: water, clear apple juice, tea or coffee without milk (possibly with sweets or sugar).
- You may no longer drink: milk (products), carbonated drinks or alcohol.

From 2 hours before the time of admission:

- You are no longer allowed to eat or drink anything (including sweets). You should also no longer chew gum.
- A sip of water to take medication - or when brushing your teeth - is allowed.

After admission to the department:

- After admission, you can still be offered up to 300 ml of ranja (that is 2 glasses) with paracetamol in the department of admission.

If you are admitted a day before surgery, follow the nursing department's instructions on fasting.

We strongly advise you not to drive yourself. Therefore, arrange someone who can take you home.

The treatment

How does the treatment work?

Where do you report?

You report to the information desk of the hospital. The employee of the Info Desk will point you further to the right department.

The nurse will receive you on the ward and prepare you further for the treatment. If it is your turn for the operation, the nurse of the department will take you to the Operation Center.

The nurse will first take you to the 'holding' area. This is the preparation room. Here the nurse will hand you over to the anaesthesia assistant.

In the holding area, we connect you to surveillance equipment. You will be given sticky pads on the chest to measure the heart rate and a clamp on your finger to check the oxygen level in your blood. You will also receive a band around your arm with which blood pressure is measured. You will also receive an infusion in your hand or arm. This allows us to give you medication.

It may be that the operator and/or the anesthesiologist will then come by to ask a few final questions. We will then take you to the operating room.

During treatment

In the operating room you will see the gynecologist who does the operation. The team goes through all the data once more. Then the anesthesiologist will give you the anesthesia via the infusion. Your bladder is emptied with a catheter.

The gynecologist makes a cut of about 1 centimeter in the lower edge of the navel and brings a thin hollow needle into the abdominal cavity. This fills the abdomen with harmless carbon dioxide. The abdomen bolts up and this creates space around the uterus, ovaries and fallopian tubes. After that, the gynecologist inserts the viewing tube with camera into the abdominal cavity.

Are the fallopian tubes closed? Then the doctor makes a 2nd cut just above the pubic bone. Because of this, the gynecologist inserts the instrument and places a clip over each fallopian tube. The fallopian tubes are immediately closed in these ways.

Are the fallopian tubes removed altogether? Then a 2nd and 3rd cut is usually made left and right at the bottom of the abdomen.
As a result, the gynecologist inserts the instruments to remove both fallopian tubes.

At the end of the operation, the gynecologist removes the viewing tube from the abdominal cavity and sucks the gas away. The gynecologist or an assistant stitches the wounds.

After treatment

What happens after treatment?

After the operation, you will be taken to the recovery room. Here your blood pressure, heart rhythm and oxygen needs are checked. If you feel well, you will be returned to the nursing ward.

The nurse does regular check-ups and informs how things are going. You will receive pain relief through the infusion. The nurse will give you information about the care of the wounds and stitches.

Home

Usually you can go home after 1 or 2 hours. It may be better to stay in the hospital for a night if you remain very nauseous or have a lot of pain.

Instantly reliable contraception

A laparoscopic sterilization is immediately reliable.

It may be necessary to use additional contraception until the first menstruation. This depends on the moment in the cycle when the sterilization is done. The doctor will discuss this with you before you go home.

At home

What to think about at home

Advice for home

- The pain usually decreases in the first hours after sterilization. Some women still suffer for a few days. If necessary, you can take painkillers. You will receive instructions about this to take home.
- You may suffer from shoulder pain. This is due to the gas in the abdomen. This can stimulate the diaphragm and you feel that as shoulder pain. This pain usually disappears the same day.
- The wounds in your abdomen are usually sutured. With the stitches you can just shower or take a bath. Usually you get soluble sutures. If they irritate, you can remove them after 5 days or have them removed.
- After a few days to a week, you can get back to work and slowly resume your other activities.

For which complaints do you call?

It is important that you call the hospital if you:

- get more and more abdominal pain;
- fever, 38°C or higher;
- one of the wounds does not heal properly.

With a sterilization, the chance of an infection is not great. If you get an infection, you will need antibiotics. With a laparoscopic sterilization, your intestine or bladder may be damaged unnoticed. You will then get more and more abdominal pain within a few days and often also fever. It rarely happens, but it is important that you call the hospital.

Do you get more pain before your check-up appointment or do you continue to have pain? Or are there other problems related to the surgery? Then call the hospital.

Training Hospital

At CMC we train nurses, co-assistants, doctors and other care providers. This means that several healthcare providers are sometimes present at your appointment. And it may be that you are being examined or treated by a healthcare provider in training. This healthcare provider always works under the supervision of a qualified healthcare provider.

Source: Jeroen Bosch