TUBAL ANASTOMOSIS

Tubal Anastomosis is a surgical procedure on the female fallopian tubes. It is performed to reverse certain types of tubal sterilizations.

Bilateral tubal ligations have been performed on over 60 million women. The request for tubal reversal or anastomosis is most commonly due to a change in a woman's marital status or a change in her desire to have more children. The use of magnification has enhanced the success rate of tubal anastomosis. Microsurgery minimizes trauma to the delicate tubal tissue. It promotes precise coagulation for bleeding, complete excision of compromised tissue and precise placement of small caliber sutures. This promotes correct alignment and approximation of the existing ends of the tubes.

The attempt to reconnect the tubes and its success depends on:

1. The type of sterilization technique utilized. Sterilization involving the application of a clip or ring, or conservative excision of a part of the tube are most easily remedied. Single burn techniques can have favorable results, but multiple burning of the tubes or placement of the Essure device have the lowest success rates.
2. The location and extent of the damage done to the tubes.
3. The status of the inner lining of the tube. This can be affected by infection, scarring and poor blood supply. If any of these are present the overall results will be reduced.
4. The length of the approximated tube and the size of the lumen (opening of the tube).

Before tubal anastomosis is scheduled the patient's partner should have a semen analysis to ensure adequacy to achieve pregnancy if he has never fathered children. Patients considering this type of surgery should obtain operative and pathology reports from their tubal ligation surgery to assist the microsurgeon in determining the feasibility of success. It is important for women to choose their microsurgeon carefully, since the initial surgical attempt is critical to the success of the procedure. Repeated tubal surgeries decreases the chance of pregnancy in the future. The procedure is performed in a Surgicenter and the patient is usually released that afternoon. A small bikini incision is made just above the pubic hair. The surgery usually takes 2 hours. During the surgery the bladder is drained with a urinary catheter. A microscopic probe is placed through the tubes to confirm patency. The lower abdominal incision is closed with dissolvable sutures. Most patients can return to work in 2 weeks.

Success of the procedure is determined by the intrauterine pregnancy rate following surgery and, with the exception of Essure or multiple burn tubal ligations, is approximately 60-70%. Most pregnancies that occur are seen in the first 18 months after surgery.

The tubes are usually patent at the end of the surgical procedure; however, the tubes may close during the healing process due to the small diameter of the tubal lumen. Patency can be evaluated by a hysterosalpingogram (HSG), an x-ray that introduces dye into the tubes. Note that occasionally following an Essure tubal anastomosis, that small metallic pieces can be seen on the HSG. These metallic fragments are usually from the foil that surrounds the Essure device or metal fragments in the fibrotic wall of the tube.

Risks of this type of surgery are minimal and may include bleeding and infection. The main risk is an increased incidence of tubal pregnancies in the future. Ectopic or tubal pregnancies could result in more damage to the tube or the need to remove a tube completely, resulting in diminished fertility. Patients with badly damaged tubes or those who had both tubes removed will require in vitro fertilization to conceive.

Tubal anastomosis is the most successful of all infertility surgeries. Women who become pregnant following this surgery need repeated blood pregnancy tests and an early ultrasound to assure pregnancy is intrauterine.

PREOPERATIVE INSTRUCTIONS

You have been scheduled to undergo surgery at: _____

Your procedure is called: Exploratory Laparotomy with Micro-Surgical Tubal Anastomosis

The date of your surgery is: _____

You should arrive at the surgery center no later than: _____

REMEMBER: Your pre-operative labs must be completed seven (7) days before your scheduled surgery date. The pre-operative labs do not have to be done fasting. The nurse will only phone regarding your lab results if they are not within normal limits.

It is very important that you do not eat or drink anything after midnight the day prior to your surgery. This includes: food, water, beverages, candy and chewing gum. Please be advised that your surgery may be cancelled if you eat or drink past midnight.

It is very important that you do not take any aspirin, diet pills, herbal supplements or vitamins, or any over-the-counter pain reliever other than Tylenol two weeks prior to your surgery. Please check with your primary care physician for instructions on what medications are okay before surgery. Please be advised that your surgery may be cancelled if any of the above listed medications are taken.

Be advised that a urine drug screen may be included in your pre-operative laboratory evaluation and your surgery may be cancelled if there is a positive test.

If you have any questions about any of these instructions or about your surgery, please contact the office at (727) 796-7705 and ask to speak with the nurse.

POST OPERATIVE INSTRUCTIONS
TUBAL REVERSAL

PAIN

- You will receive a prescription for pain medication the day of surgery.
- A long-lasting local anesthetic will be injected into the tissue below your incision to assist in pain relief. This may make the area feel numb for a few days. Significant pain/discomfort will last for 2 – 3 days and should improve. Moderate pain may last up to two weeks.

FOOD

- The evening of surgery only a clear liquid diet is recommended such as water, juice, soup. Avoid dairy products: no milk shakes or cream soups.
- The day after surgery you may resume a normal diet.

INCISION

- Leave the bandage on the incision for 2 days. Keep the incision area dry to prevent infection. Upon removing the bandage you will note steri-strips across the incision. Do not remove the steri-strips.
- Remove the steri-strips one week after the surgery. At this time apply vitamin E (oil, lotion, gel) to the incision for 2 to 4 weeks.
- The suture is under the skin and will dissolve on its own. This may take several weeks.
- If the incision pulls apart, please call our office and speak with the nurse. This may occur more commonly in overweight individuals or in women who have had several abdominal surgeries such as c-sections.
- When the bandage is removed (post-op day 2) you may shower. Pat dry after shower and keep as dry as possible. We recommend no bathing or submerging in water for 2 weeks.
- No lifting of over 10 lbs for 4 weeks following the surgery.
- It is generally 5-7 days before returning to light activity.

AFTER CARE

- The week after surgery, local patients will be seen in office for a post-op visit. Our nurse will call any patient living outside our area and review your surgical outcome.
- It is important you establish with a high-risk OBGYN and be seen at the first sign of pregnancy.
- A copy of your surgery report will be mailed to you within two weeks of your surgery. You will receive a copy for your personal records and one to provide to the high-risk provider you select.
- Please remember you are at an increased risk of tubal (ectopic) pregnancy and need to be seen at the first sign of pregnancy.
- A catheter is placed in the bladder during the surgical procedure; therefore, it is common to experience burning with urination following the surgery. This should improve within a week after the surgery.
- If you develop a fever of over 100.5, take fluids and Tylenol. If the fever persists, contact our office.
- Wait a minimum of 4-6 weeks before resuming sexual activity, then use condoms or birth control until after your 3rd menses (period) from surgery date.
  Example) Surgery Date: September = Resume sexual activity After menses (period) in December.

EMERGENCY PHONE# 727-796-7705

Ectopic Pregnancy

Ectopic pregnancy is any pregnancy that implants in a site other than the uterine cavity.

During a normal pregnancy, an egg becomes fertilized by a sperm inside the fallopian tube. The fertilized egg travels down through the fallopian tube and into the uterus, where it implants itself on the inside wall. An ectopic pregnancy occurs when the embryo implants itself outside the uterus. In most cases, ectopic pregnancy occurs in a fallopian tube—a fertilized egg becomes trapped there and implants itself. Although more rare, ectopic pregnancy can also occur in other places such as on an ovary, within the cervix, or in the abdomen.

Symptoms of ectopic pregnancy may include irregular bleeding after a missed period, lower abdominal pain, and lower back pain. If you have these symptoms, call your doctor right away—an ectopic pregnancy can become a serious, life-threatening medical emergency if it is not diagnosed and treated early. Your fallopian tube can rupture from the growing embryo, resulting in severe pain, uncontrolled internal bleeding, and shock. A history of Gonorrhea or Chlamydia may increase your risk of having an ectopic pregnancy. Surgery for adhesions or blocked tubes or a tubal reversal may increase your risk of an ectopic pregnancy.

How ectopic pregnancy is diagnosed

Your medical history and a pelvic exam are helpful in diagnosing ectopic pregnancy. However, other tests are needed to confirm the diagnosis. You may need one or more of the following tests:

- **hCG (human chorionic gonadotropin) test**—a blood test that confirms pregnancy by measuring the amount of hCG (a hormone produced by the pregnancy) in your blood; often, this test is repeated every 2 days
- **Ultrasound**—a scan that uses high-frequency sound waves to determine where the embryo has implanted itself
- **Progesterone** – a blood test measures the progesterone level which may be low in an ectopic pregnancy.

Questions & Answers

Q. What causes an ectopic pregnancy?
A. The cause is often unknown. However, ectopic pregnancy tends to occur when the fallopian tube has become damaged in some way—from a previous infection, endometriosis, tubal surgery, or even a previous ectopic pregnancy. Scar tissue that is partially blocking the inside of the fallopian tube can trap the fertilized egg, resulting in an ectopic pregnancy.

Q. What treatments are available to me?
A. Your treatment will depend on how early the ectopic pregnancy is discovered. If you are in a lot of pain and have heavy internal bleeding, you will likely need emergency surgery to stop the bleeding. The surgery may involve either removing the embryo from your tube or removing the segment of the tube containing the embryo. If the ectopic pregnancy is discovered early, before the embryo has grown large enough to rupture your fallopian tube, an injection of a medication, methotrexate, may be an option. Methotrexate prevents the rapid division of cells in early pregnancy, thereby ending the pregnancy.

Q. How will an ectopic pregnancy affect my chances for a successful pregnancy in the future?
A. Ectopic pregnancy can damage your fallopian tube, which may reduce your chances for future normal pregnancies. In addition, women who have had an ectopic pregnancy are at increased risk for a future ectopic pregnancy. Your doctor will discuss treatment options that may increase your chance for pregnancy.