Complete Summary

GUIDELINE TITLE

Male and female sterilisation.

BIBLIOGRAPHIC SOURCE(S)

Royal College of Obstetricians and Gynaecologists (RCOG). Male and female sterilisation. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2004 Jan. 114 p. (Evidence-based Clinical Guideline; no. 4). [285 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Royal College of Obstetricians and Gynaecologists (RCOG). Male and female sterilisation. London: RCOG Press; 1999 Apr. 86 p. (Evidence-based clinical guidelines; no. 4).

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SCOPE

DISEASE/CONDITION(S)

Unintended pregnancy

GUIDELINE CATEGORY

Counseling
Management
Prevention

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Nursing
Obstetrics and Gynecology
Urology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To inform health care providers and purchasers so that patients receive a high quality service based on the best evidence available

TARGET POPULATION

Men and women who request sterilisation

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation

1. Patient counseling and provision of information about sterilisation procedures
2. Patient history and physical examination
3. Pregnancy test in females
4. Assessment for concurrent conditions which may require an additional or alternative procedure or precaution

Sterilisation Procedures

Treatment of the Male Patient (Vasectomy)

1. No-scalpel vasectomy
2. Division of each vas accompanied by fascial interposition or diathermy
3. Local and general anaesthesia (local anaesthesia is preferred)
4. Histological examination of excised portions of vas (only if there is any doubt about their identity)
5. Post vasectomy semen analysis
6. Special clearance to discontinue contraception (in men where non-motile sperm persist after vasectomy)

Treatment of the Female Patient (Tubal Occlusion)

1. Laparoscopy, mini-laparotomy, and laparotomy for access to the fallopian tubes
2. Mechanical tubal occlusion with rings or clips
3. The Pomeroy, Parkland or Pritchard (modified Pomeroy), Irving, Cooke, Uchida, and Wood, techniques for tubal ligation
4. Hysteroscopic methods for tubal occlusion
5. General anesthesia and local anaesthesia with or without sedation and local tubal anaesthesia for post-operative pain relief

Note: The following procedures were considered but not recommended: culdoscopy, the Madlener technique and fimbriectomy, diathermy as a primary method of tubal occlusion, and dilatation and curettage to prevent luteal phase pregnancy.

MAJOR OUTCOMES CONSIDERED

- Success and failure rates of vasectomy and tubal occlusion (e.g., post-procedure pregnancy rate)
- Ease of reversibility
- Ectopic pregnancy rate
- Complication rates (e.g., risk of visceral injury)
- Pain and/or discomfort
- Patient satisfaction
- Post operative menstrual irregularities

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Search Strategy

Individual searches were carried out for each topic of interest. For each subject, including foreign language publications, the electronic database MEDLINE (CD Ovid version) was searched for the time period January 1966 to December 2002. The searches were performed using relevant Medical Subject Headings (MeSH) terms and relevant text words. In addition, the electronic database EMBASE was searched for the period between 1974 and December 1997 to identify those publications (usually European) not indexed on MEDLINE. The Cochrane Library was also searched up to Issue 4, 2002, to identify published systematic reviews, meta-analyses, and controlled clinical trials. Reference lists of non-systematic review articles and studies obtained from the initial search were trawled, and journals in the Royal College of Obstetricians & Gynaecologists (RCOG) library were hand-searched to identify articles not yet indexed. Experts on the guideline development group were also asked to identify key references. There was no systematic attempt to search the "grey literature" (conference abstracts, theses, unpublished trials).

Reviewing the Literature

For all subject areas, published systematic reviews or meta-analyses were used. If these did not exist, randomised controlled trials (RCTs) were obtained. If there were no published RCTs, or if RCTs were not appropriate for a particular clinical question, other appropriate experimental or observational studies were sought. Articles were initially retained after reading their title and abstract. The full papers were then obtained and read. Articles not relevant to the subject in question were rejected, as were articles where desired outcomes were not reported.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1a: Evidence obtained from systematic review of meta-analysis of randomised controlled trials
1b: Evidence obtained from at least one randomised controlled trial
2a: Evidence obtained from at least one well-designed controlled study without randomisation
2b: Evidence obtained from at least one other type of well-designed quasi-experimental study
3: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies
4: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Identified articles were assessed methodologically, and the best evidence was used to form and support the recommendations. If a question could be answered by a good systematic review, meta-analysis, or randomised controlled trial, then studies of weaker design were ignored. The evidence was synthesised using qualitative methods. These involved summarising the content of identified papers into brief statements that accurately reflected the relevant evidence. Quantitative techniques (meta-analysis), apart from those published, were not performed, due to time constraints and the difficulty of combining studies of various designs.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The recommendations were graded according to the level of evidence upon which they were based. The grading scheme used was based on a scheme formulated by the Clinical Outcomes Group of the National Health Service (NHS) Executive.

Grade A - Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence levels 1a, 1b)

Grade B - Requires the availability of well-conducted clinical studies but no randomised clinical trials on the topic of the recommendation (evidence levels 2a, 2b, 3)

Grade C - Requires evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates an absence of directly applicable clinical studies of good quality (evidence level 4)

COST ANALYSIS

Although some published cost analyses were reviewed during guideline preparation, the cost implications of implementing this guideline have not been considered in detail.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The 1999 Guideline

After the initial draft of the guideline had been written and approved by the guideline group, a formal peer review process was undertaken. Each member of the guideline group put forward six to eight names of individuals or organisations from the area of practice that they represented. A copy of the draft guideline, together with a guideline appraisal document based on that used by the Scottish Intercollegiate Guidelines Network, was sent out to 59 nominated people. Replies were received from 39 reviewers (37 completed the form; two others provided written comments only), a response rate of 66%.

All comments from this peer review were discussed by the guideline group and amendments agreed by informal consensus. There was little dissent among the peer reviewers with regard to the recommendations. Suggested amendments mainly concerned style, presentation, and typography. There were also requests

from peer reviewers for expansion on the evidence in certain areas. None of the recommendations was substantially changed as a result of the peer review.

The Revised Guideline

The members of the original guideline development group were invited to make comments on areas to be considered for this revision. Replies were received from eight of them, including a consumer representative and a representative of the Royal College of Nursing. A first draft of the revised guideline was circulated to members of the Royal College of Obstetricians & Gynaecologists (RCOG) Guidelines and Audit Committee, who made comments on it and approved it for peer review. The guideline, together with guidance on appraisal, was sent out to the nine members of the original guideline development group and seven other nominated people. Replies were received from 12 of the peer reviewers, a response rate of 75%. Comments on the draft posted on the RCOG website were received from four people.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the original guideline document.

Levels of evidence (1a-4) and grading of recommendations (A-C) are defined at the end of the Major Recommendations field.

General

Indications for or Against Sterilization

C - If there is any question of a person not having the mental capacity to consent to a procedure that will permanently remove their fertility, the case should be referred to the courts for judgment.

C - Additional care must be taken when counselling people under 30 years of age or people without children who request sterilisation.

What is Required Before the Procedure is Performed?

C - All verbal counselling advice must be supported by accurate, impartial printed or recorded information (in translation, where appropriate and possible), which the person requesting sterilisation may take away and read before the operation.

C - Counselling and advice on sterilisation procedures should be provided to women and men within the context of a service providing a full range of information about and access to other long-term reversible methods of contraception. This should include information on the advantages, disadvantages, and relative failure rates of each method.

C - Both vasectomy and tubal occlusion should be discussed with all men and women requesting sterilisation.

B - Women in particular should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancies and that there is less risk related to the procedure.

C - A history should be taken and an examination should be performed on all men and women requesting vasectomy or tubal occlusion.

C - The operating doctor will need to ensure that the counselling, information exchange, history, and examination have been completed and be satisfied that the patient does not suffer from concurrent conditions which may require an additional or alternative procedure or precaution.

Tubal Occlusion

Methods

A - Culdoscopy should not be used as a method of approach for sterilisation.

A - Where equipment and trained staff are available, the laparoscopic approach to the fallopian tubes is quicker and results in less minor morbidity compared with mini-laparotomy.

B - Any effective surgical or mechanical method of tubal occlusion can be used when a mini-laparotomy is used as the method of approach for an interval sterilisation.

B - A modified Pomeroy procedure rather than Filshie clip application may be preferable for postpartum sterilisation performed by mini-laparotomy or at the time of caesarean section, as this leads to lower failure rates.

A - Mechanical occlusion of the tubes by either Filshie clips or rings should be the method of choice for laparoscopic tubal occlusion.

C - The routine use of more than one Filshie clip is not recommended.

C - Diathermy should not be used as the primary method of tubal occlusion because it increases the risk of subsequent ectopic pregnancy and is less easy to reverse than mechanical occlusive methods.

C - Hysteroscopic methods of tubal occlusion are still under evaluation and should only be used within the present guidance system for new surgical interventions.

Information

B - Women, particularly those at increased risk from conditions such as previous abdominal surgery or obesity, should be informed of the risks of laparoscopy and the chances of laparotomy being necessary if there are problems with laparoscopy.

Anaesthesia

A - While recognising that general anaesthesia is usually used in the United Kingdom (UK) for laparoscopic tubal occlusion, local anaesthesia is an acceptable alternative.

C - Laparoscopic tubal occlusion should be performed as a day case wherever possible.

A - Topical application of local anaesthesia to the fallopian tubes should be used whenever mechanical occlusive devices are being applied either under general or local anaesthesia.

Failure

B - Women should be informed that tubal occlusion is associated with a failure rate and that pregnancy can occur several years after the procedure. The lifetime risk of failure in general is estimated to be one in 200. The longest period of follow-up data available for the most common method used in the UK, the Filshie clip, suggests a failure rate after ten years of two to three per 1,000 procedures.

B - Women should be informed that, if tubal occlusion fails, the resulting pregnancy may be ectopic.

Timing

B - Tubal occlusion should be performed after an appropriate interval following pregnancy wherever possible. Should tubal occlusion be requested in association with pregnancy (either postpartum or post-abortion), the woman should be made aware of the increased regret rate and the possible increased failure rate.

C - If tubal occlusion is to be performed at the same time as a caesarean section, counselling and agreement should have been given at least one week prior to the procedure.

B - Tubal occlusion can be performed at any time during the menstrual cycle, provided that the clinician is confident that the woman has used effective contraception up to the day of the operation. If this is not the case, the operation should be deferred until the follicular phase of a subsequent cycle. The woman should be advised to continue to use effective contraception until her next menstrual period.

B - A pregnancy test must be performed before the operation to exclude the possibility of a preexisting pregnancy. However, a negative test does not exclude the possibility of a luteal-phase pregnancy.

B - Routine curettage at the time of tubal occlusion, in order to prevent a luteal-phase pregnancy, is not recommended.

Reversal

B - Although women requesting sterilisation should understand that the procedure is intended to be permanent, they should be given information about the success rates associated with reversal, should this procedure be necessary.

Risks

B - Women should be reassured that tubal occlusion is not associated with an increased risk of heavier or irregular periods when performed after 30 years of age. There is an association with subsequent increased hysterectomy rate, although there is no evidence that tubal occlusion leads to problems that require a hysterectomy. Data are limited on the effect on menstruation when tubal occlusion is performed on women under 30 years of age.

Training

C - Trainees should perform at least 25 supervised laparoscopic tubal occlusions before operating without supervision.

Vasectomy

Methods

A - Except when technical considerations dictate otherwise, a no-scalpel approach should be used to identify the vas, as this results in a lower rate of early complications.

A - Division of the vas on its own is not an acceptable technique because of its failure rate. It should be accompanied by fascial interposition or diathermy.

B - Clips should not be used for occluding the vas, as failure rates are unacceptably high.

Anaesthesia

C - Vasectomy should be performed under local anaesthetic wherever possible.

Histological Examination

C - Excised portions of vas should only be sent for histological examination if there is any doubt about their identity.

Post-Vasectomy Semen Analysis

C - Men should be advised to use effective contraception until azoospermia has been confirmed. The way in which azoospermia is confirmed will depend upon local protocols.

A - Irrigation of the vas during vasectomy does not reduce failure rates or time to clearance.

Special Clearance

C - In a small minority of men, non-motile sperm persist after vasectomy. In such cases, "special clearance" to stop contraception may be given when less than 10, 000 non-motile sperm/milliliter (mL) are found in a fresh specimen examined at least seven months after vasectomy, as no pregnancies have yet been reported under these circumstances.

Failure

B - Men should be informed that vasectomy has an associated failure rate and that pregnancies can occur several years after vasectomy. The rate should be quoted as approximately one in 2,000 after clearance has been given.

Reversal

B - Although men requesting vasectomy should understand that the procedure is intended to be permanent, they should be given information on the success rates associated with reversal, should this procedure be necessary.

Risks

B - Men requesting vasectomy can be reassured that there is no increase in testicular cancer or heart disease associated with vasectomy. The association, in some reports, of an increased risk of being diagnosed with prostate cancer is at present considered likely to be noncausative.

B - Men should be informed about the possibility of chronic testicular pain after vasectomy.

Training

C - Practitioners who are being trained to perform vasectomies should ensure that their training conforms to that advocated by the Faculty of Family Planning and Reproductive Health Care. Doctors with no prior experience should be supervised for ten operating sessions or 40 procedures, while doctors with relevant prior surgical experience should perform eight supervised procedures.

Audit

C - A national register and audit of failed sterilisations is needed. Hospital-based registers of sterilisation procedure failures would assist this.

Definitions:

Levels of Evidence

1a: Evidence obtained from systematic review of meta-analysis of randomised controlled trials
1b: Evidence obtained from at least one randomised controlled trial
2a: Evidence obtained from at least one well-designed controlled study without

randomisation
2b: Evidence obtained from at least one other type of well-designed quasi-experimental study
3: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies
4: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grading of Recommendations:

Grade A - Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence levels 1a, 1b)

Grade B - Requires the availability of well-conducted clinical studies but no randomised clinical trials on the topic of the recommendation (evidence levels 2a, 2b, 3)

Grade C - Requires evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates an absence of directly applicable clinical studies of good quality (evidence level 4)

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

It is anticipated that there will be health benefits for men and women in the form of better information and service provision.

POTENTIAL HARMS

Vasectomy

- Chronic testicular pain that develops immediately or a few months after the vasectomy is an important post-vasectomy complication.
- Early complications include post-operative skin bleeding and scrotal hematoma.
- Two reviews suggest that hospitalization rates for diseases of the genitourinary system (kidney or bladder infection, epididymitis/orchitis) were

higher in men with vasectomies compared to those without during the early postvasectomy period (up to two years after the procedure).
- Men should be informed that vasectomy has an associated failure rate and that pregnancies can occur several years after vasectomy.
- Vasectomy should be delayed in the presence of scrotal skin infection, active sexually transmitted disease, balanitis, epididymitis, orchitis, and systemic infection or gastroenteritis, due to an increased risk of post-operative infection; and in the presence of an intrascrotal mass, which may indicate underlying disease. Caution is needed when a large varicocele or hydrocele (which may make the vas difficult or impossible to locate) or previous scrotal injury is present; specialist referral may be necessary.

Tubal Occlusion Procedures

- Major complications of laparoscopic surgery include injuries to bowel, bladder, or blood vessels that require laparotomy or lead to death.
- Complications of unipolar electrocoagulation include thermal injury to the bowel, burns to the skin, and death. Bowel perforation caused by diathermy burns can present late; typically, patients present 3 to 7 days after the procedure with complaints of fever and abdominal pain, although presentation can sometimes be a couple of weeks later. If left untreated, peritonitis and then septicemia can occur. Several deaths in women, from unrecognized bowel burns after unipolar cautery, have been reported.
- The risk of an ectopic pregnancy is high in pregnant women who have been sterilized previously. Ectopic pregnancies are currently the greatest single cause of first trimester maternal deaths and account for 6.25% of all direct maternal deaths in the United Kingdom. Ectopic pregnancies are more likely if tubal diathermy was used and are less likely with either tubal ligation or mechanical occlusive methods.
- Tubal occlusion is associated with a failure rate and that pregnancy can occur several years after the procedure.
- There will always be some women who regret their decision to be sterilised. The proportion of women expressing this regret varies between different studies and different countries but tends to range from 3% to 10% in the United Kingdom.
- In a multicenter prospective observational study, the most frequently encountered association with complications of laparoscopy was a previous laparotomy.
- General anaesthesia, previous abdominal/pelvic surgery, previous pelvic inflammatory disease, and obesity have been reported to significantly increase the relative risk of complications of laparoscopy and need for laparotomy.

CONTRAINDICATIONS

CONTRAINDICATIONS

Vasectomy

Contraindications to vasectomy under local anaesthesia include a history of allergy to local anaesthetic, a history of fainting easily, and patient refusal of local anaesthesia.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The guideline points towards best practice but does not preclude alternatives that can be justified on the basis of the individual needs of the case or special skills and innovations that are subject to ethically approved research. Particular attention should be paid to the estimate of average lifetime postoperative pregnancy rates and the specific consent issues that should be addressed in every case.
- Guidelines are "systematically developed statements to assist decisions about appropriate care for specific clinical circumstances." Practitioners are expected to use the recommendations in the light of each particular patient's circumstances and the resources available.
- The original guideline document is driven by patients' preferences as the initial request for sterilisation comes from the patient. Throughout the guideline, emphasis has been placed on the importance of information provision to patients and the importance of choice with regard to long-term contraceptive methods whether it be tubal occlusion, vasectomy or some other method. The guideline group acknowledges that people seeking such procedures are not ill but nevertheless the term "patient" has been used throughout the original guideline to maintain consistency.
- Product liability: the Royal College of Obstetricians & Gynaecologists (RCOG) can give no guarantee for information about drug dosage and application thereof contained in this guideline. In every individual case the respective user must check its accuracy by consulting other pharmaceutical literature.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Local Adaptation, Dissemination, and Implementation

It has been shown that local adaptation enhances the implementation and compliance to guidelines, and it is anticipated that this national guideline will be used as the basis for such local adaptation based on local resources, community needs, and patterns of service provision. Local adaptation should take place in a multidisciplinary group, with collaboration between all interested parties that would be affected by the guidelines. It is essential that commissioners of healthcare, as well as general practitioners and specialists, take part in such a process. A variety of approaches may be necessary to disseminate and implement the local protocols, e.g., distribution of printed protocols to all local general practitioners, specialists, and trainees, Postgraduate Educational Allowance (PGEA) sessions in the evening for general practitioners, postgraduate meetings in hospitals, and audit sessions.

Clinical Audit

The Patient Record Standard for Female Tubal Occlusion Procedures in Women (Appendix 2 of the original guideline document) could be used to form the basis for audit.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Patient Resources
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Royal College of Obstetricians and Gynaecologists (RCOG). Male and female sterilisation. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2004 Jan. 114 p. (Evidence-based Clinical Guideline; no. 4). [285 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999 Apr (revised 2004 Jan)

GUIDELINE DEVELOPER(S)

Royal College of Obstetricians and Gynaecologists - Medical Specialty Society

SOURCE(S) OF FUNDING

This guideline was developed with funding from the Clinical Effectiveness Programme of the UK Department of Health, National Health Service (NHS) Executive with additional support from the Royal College of Obstetricians and Gynaecologists (RCOG).

GUIDELINE COMMITTEE

RCOG Guidelines and Audit Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Royal College of Obstetricians and Gynaecologists (RCOG) Guidelines and Audit Committee Members: Miss MC Davies MRCOG (Chair); Dr R Anderson MRCOG; Ms T Belfield (Consumer representative), Family Planning Association; Mrs C Dhillon, Head of Clinical Governance and Standards, RCOG; Miss LMM Duley FRCOG; Professor NM Fisk FRCOG, Chairman of the RCOG Scientific Advisory Committee; Mr JM Jenkins FRCOG; Dr KS Khan MRCOG; Miss PM Kyle MRCOG; Professor WL Ledger FRCOG; Dr G Lewis, Department of Health; Dr MAC Macintosh MRCOG; Dr D Rajasingam MRCOG (Trainees' representative); Ms W Riches, National Institute for Clinical Excellence; Mr IV Scott FRCOG; Mr MI Shafi MRCOG; Miss JM Thomas MRCOG, Director, National Collaborating Centre for Women's and Children's Health

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Royal College of Obstetricians and Gynaecologists (RCOG). Male and female sterilisation. London: RCOG Press; 1999 Apr. 86 p. (Evidence-based clinical guidelines; no. 4).

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Royal College of Obstetricians and Gynaecologists Web site.

Print copies: Available from the Royal College of Obstetricians and Gynaecologists (RCOG) Bookshop, 27 Sussex Place, Regent's Park, London NW1 4RG; Telephone: +44 020 7772 6276; Fax, +44 020 7772 5991; e-mail: bookshop@rcog.org.uk. A listing and order form are available from the RCOG Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Male and female sterilization. Guideline summary. London: RCOG Press; 2004 Jan. 18 p.

Electronic copies: Available in Portable Document Format (PDF) from the Royal College of Obstetricians and Gynaecologists Web site.

Additionally, the patient record standard in Appendix 2 in the original guideline document could be used to form the basis for audit.

PATIENT RESOURCES

The following is available:

- Sterilisation for women and men: what you need to know. Royal College of Obstetricians and Gynaecologists (RCOG), 2004 Jan. 13 p.

Electronic copies: Available from the Royal College of Obstetricians and Gynaecologists Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on January 8, 2001. It was verified by the guideline developer as of February 6, 2001. This NGC summary was updated by ECRI on September 9, 2005. The updated information was verified by the guideline developer on October 11, 2005.

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