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CORRESPONDENCE

Correspondents are asked to be brief

One Thousand Vasectomies

SIR,—The article by the staff of the Margaret Pyke Centre on vasectomy (27 October, p. 216) is a timely and reasoned approach to a problem about which we as yet still do not have accurate information. This is an emotive subject because it affects the public at large in a most sensitive field and it has also been dragged into the political arena. I think the authors have been wise to confine themselves to objective analysis.

This publication has coincided with a review of a series of 223 patients of my own who underwent bilateral vasectomy and I would like the opportunity to comment through your columns. I undertake my own counselling, not because I do not have any ancillary help but because I believe that it is incumbent upon a surgeon who is carrying out an operation to be aware of the implications of that procedure and not merely to act as a technician. I emphasize that the operation I perform is absolutely irreversible, but I note that the authors use the words "virtually irreversible"; this indicates equivocation in their own mind and this will undoubtedly be transmitted to the patient, particularly if he is pressing. As with other programmes which are aimed at otherwise well people (cancer screening, etc.), I find that my patients consist of the more highly motivated members of the middle and artisan classes.

The burden of the article from the surgical point of view was concerned with the assessment of sterility and whether the presence of non-motile spermatozoa in the ejaculate was of significance. The authors state, however, that many of the specimens were examined up to 48 hours after ejaculation, and after this interval it would be surprising if any spermatozoa were motile; when fresh, however, they would still retain their potency. Much of the doubt about the after-effects of the operation in terms of fertility would be relieved by a different and more efficient surgical technique. My practice has been not only to resect a minimum of 2·5 cm of the vas on each side, but to double each end back on itself for a distance of 1·5 cm and double-ligate each end with a non-absorbable suture. This effectively destroys a minimum of 7·5 cm of the vas; I take care to replace the ends in the anatomical position so that the distance between them is maintained. I submit that the worrying sperm granulomata found in five of the published cases would not be possible under these circumstances. There is a disadvantage, however, in that efficient mobilization of the vas is painful and requires a general anaesthetic; there is more postoperative pain in these cases than those treated under a local anaesthetic, but this subsides within a few days. In no case have I found it necessary to reoperate for haematoma and there has been no incidence of scrotal infection; in one case the wound gaped owing to excessive tension on the skin sutures which cut through.

Assessment of sterility has been left to the end of the fourth month, by which time 91% of patients produce two specimens which contain no spermatozoa at all. The remainder have been reassessed monthly after producing two further specimens and all have become azoospermic within a further four months, except for three patients in whom this result was not achieved until 12, 14, and 15 months after operation, respectively. One of the latter patients was advised to undergo reexploration, but he refused and the semen later became negative.

I would agree with the authors that there is no such thing as a guarantee in medicine, but I believe that with a radical and efficient technique the possibility of conception is minimal, and certainly in this smaller series it has never arisen. The Margaret Pyke Centre obviously offers a valuable service which is based on volume and a large turnover; I would suspect, however, that a more individual approach to each patient, though more time-consuming and requiring more resources, may in the long run be more efficient.—I am, etc.,

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SIR,—May I comment upon the series of 1,000 vasectomies reported by the staff of the Margaret Pyke Centre (27 October, p. 216)?

It is stated that after vasectomy "within 48 hours of collection each [semen] specimen was . . . examined . . . for the presence of spermatozoa. . . ." As will be known by any doctor practising artificial insemination by donor for infertility, it is essential for semen to be examined within two hours of ejaculation in order to assess sperm motility and viability. I would expect no sperms to be motile after 48 hours and the great majority to be dead. Delay in examination may explain why some patients' wives subsequently