Policy for Vasectomy
The CCG policy has been reviewed and developed by the Treatment Policies Clinical Development Group in line with the groups guiding principles which are:

1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment;
2. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment;
3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor;
4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment;
5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community
6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance;
7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered; AND
8. All policy decision are considered within the wider constraints of the CCG’s legally responsibility to remain fiscally responsible.
Vasectomy

A vasectomy is a surgical procedure performed on males in which the vas deferens (tubes that carry sperm from the testicles to the seminal vesicles) are cut, tied, cauterized (burned or seared) or otherwise interrupted. The semen no longer contains sperm after the tubes are cut, so conception cannot occur. The testicles continue to produce sperm, but they die and are absorbed by the body.

The purpose of this operation is to provide reliable contraception. Vasectomy is the most reliable method of contraception.

Vasectomy is the technique of interruption of the vas deferens with an intention to provide permanent contraception. The procedure can be performed under local or general anaesthesia. The traditional method involves making one or two incisions in the scrotal skin to expose the vas deferens. The vas deferens is then occluded and divided using various techniques.

A relatively new technique to expose the vas, the no-scalpel vasectomy (NSV), involves a puncture wound in the scrotal skin to access and occlude the vas. Following anaesthesia, a specially designed fixation clamp encircles and firmly secures the vas without penetrating the skin. Sharp-tipped dissecting forceps are then used to puncture the skin and vas sheath and to stretch a small opening in the scrotum. The vas is lifted and occluded, as with other vasectomy techniques. The same puncture hole can be used for the opposite vas or a separate puncture can be made. A number of NSV techniques are reported in the literature. It has been suggested that these techniques should not be referred to as NSV but instead be referred to as minimally invasive vasectomy (MIV). For the purposes of this policy, the term MIV will be used to encompass NSV and any modified versions of this technique where the skin opening is ≤10 mm, and the dissection area surrounding the vas deferens is minimised and does not require the use of skin sutures. MIV may include the use of a variety of surgical instruments, including a scalpel, to expose the vas.

Vasectomy should be performed under local anaesthesia wherever possible.

Post-vasectomy semen analysis (PVSA) should be carried out to identify early failure. Additional contraception should be used until azoospermia is confirmed or special clearance given. Evidence suggests that 12 weeks post-vasectomy is the optimal timing to schedule the first PVSA. Earlier or later testing is acceptable taking into account that earlier testing increases the probability of additional tests and later testing prolongs the need for additional contraception.

A routine second PVSA is not required if azoospermia is found in the first sample.
### Eligibility Criteria

The CCG will fund vasectomy in the following circumstances:

- The man (and where possible his partner) have given fully informed consent for the permanent sterilisation procedure and have been informed that reversal of sterilisation is not available on the NHS and reversal of sterilisation has poor success rates. **AND**

- Minimally invasive vasectomy is the first choice of procedure under local anaesthetic in a commissioned community clinic setting. **AND**

- The patient has been fully informed of the postoperative follow-up and post procedure semen analysis

Vasectomy will be funded in an in-patient setting under general anaesthetic **ONLY** in the following circumstances:

- The patient is allergic to local anaesthetic **OR**
- The patient is taking anticoagulants or antiplatelet medications and risk of haemorrhage (bleeding) is high **OR**
- The patient has anatomic abnormalities, i.e. there is an inability to palpate and mobilize both vas deferens or large hydroceles or varicoceles **OR**
- There is past trauma which has resulted in scarring of the scrotum which would require surgery in an in-patient setting.

This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

### Guidance

NHS Choices. 2017. Vasectomy

[https://www.nhs.uk/Video/Pages/Vasectomy.aspx](https://www.nhs.uk/Video/Pages/Vasectomy.aspx)


