

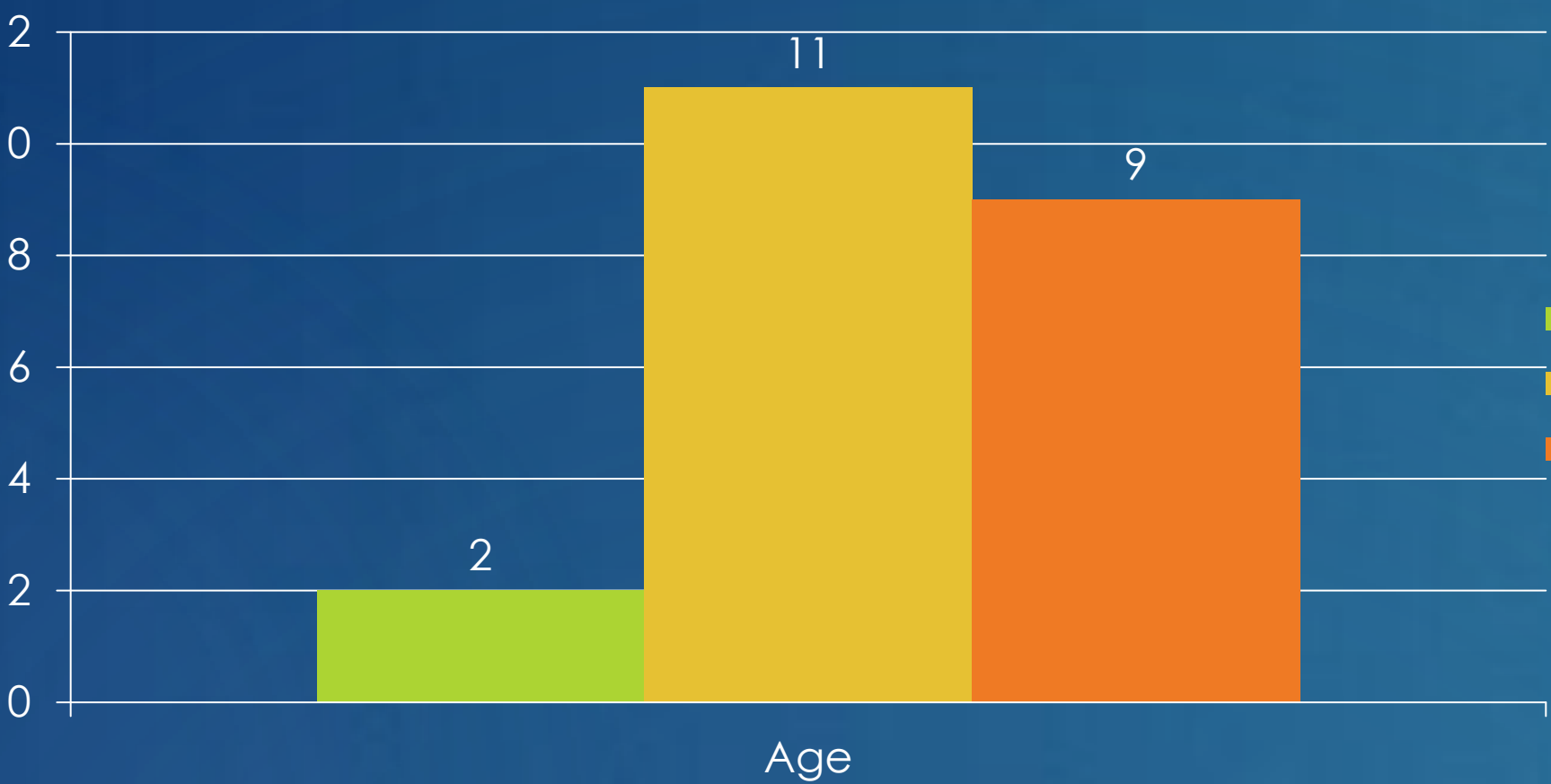
Impact of Covid Pandemic on Sterilisation Services

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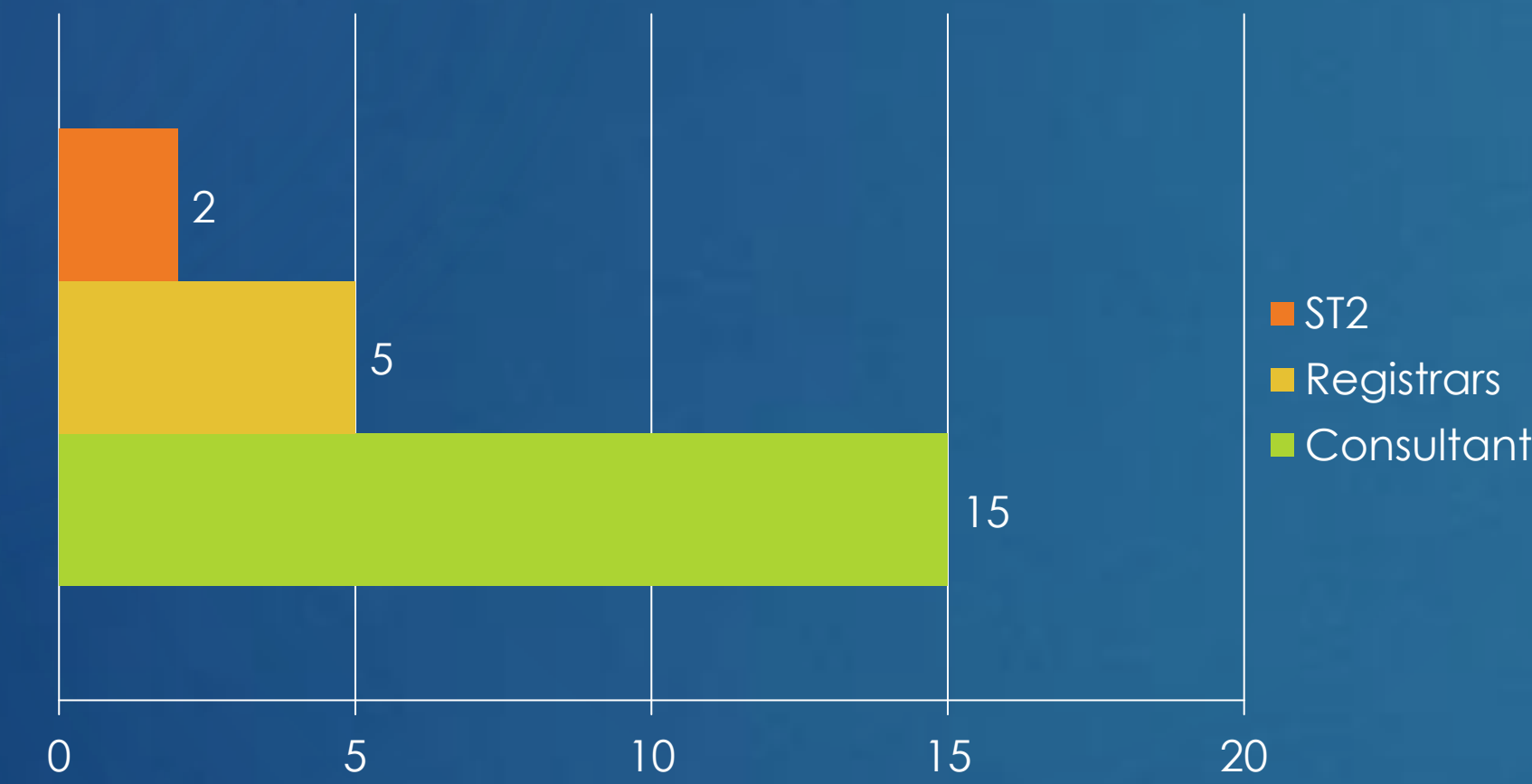
OBJECTIVE: TO EVALUATE THE QUALITY OF COUNSELLING PRIOR TO A LAPAROSCOPIC STERILISATION AND ASSESS THE IMPACT OF COVID ON THE WAITING TIME FOR THE SERVICE AT LANCASHIRE TEACHING HOSPITALS (LTHTR)

STUDY PERIOD Two years Duration, 2020 and 2021
Guidelines to compare
Consent Advice No. 3 Female Sterilisation RCOG
FSRH Male and Female Sterilisation 2014

RESULTS
22 women had laparoscopic sterilisation in the last two years compared to 55 women in 2019
Parity Range: From 1 to 6
Age Range: 27-47



CONSENT



COUNSELLING

Vasectomy	11	(50%)
LARC	16	(72.7%)
Reversal	15	(68%)
Failure Rate	19	(86.3%)
Regret	6	(27%)

LAPAROSCOPIC APPROACH

The laparoscopic approach to the fallopian tubes is quicker to perform and results in less minor morbidity compared to mini-laparotomy. (FSRH)

All women had laparoscopic surgeries. 100%

FILSHIE CLIPS

Mechanical occlusion of the fallopian tubes by Filshie clips should be the method of choice for laparoscopic tubal occlusion. (FSRH)

Majority (20/22) had Filshie clips, two women required salpingectomy (had Essure previously).

NO OF CLIPS

The routine use of more than one Filshie clip is not recommended. (FSRH)

Only one lady had two clips due to incomplete occlusion of the right tube.

PREGNANCY TEST

A pregnancy test must be performed before sterilization to exclude possibility of a preexisting pregnancy. (FSRH)

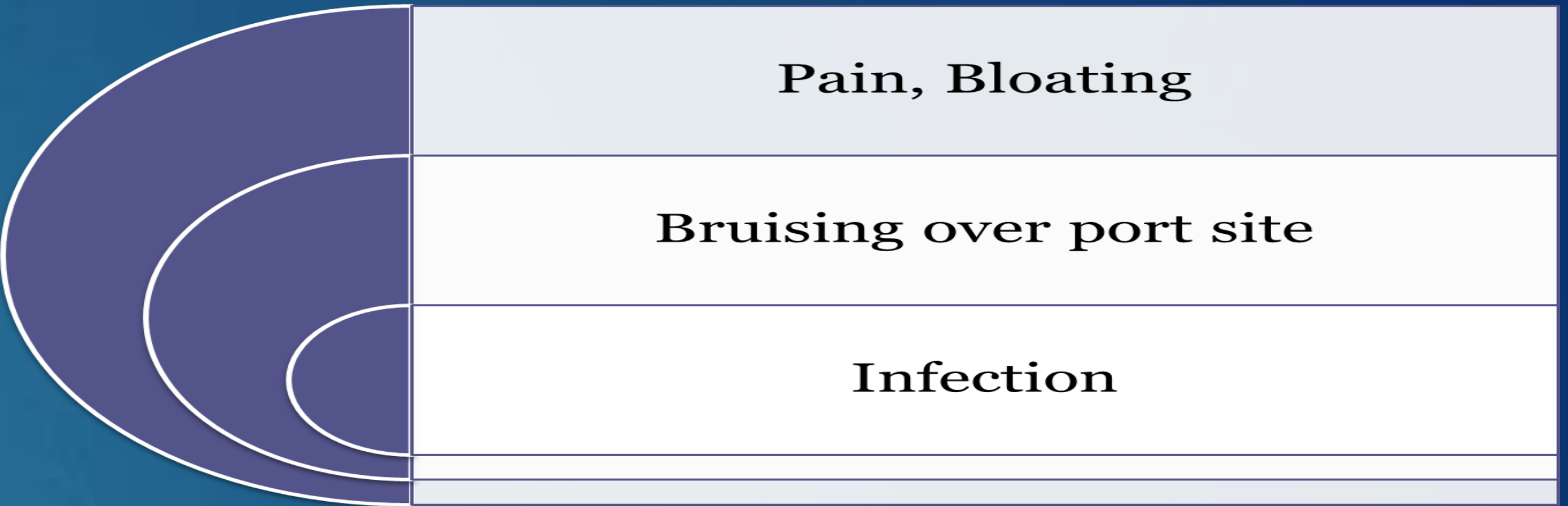
Written consent was taken in 100 % cases and PT was performed in all women immediately prior to the procedure.

CONTINUATION OF CONTRACEPTION

Women using CHC, POP or non-hormonal contraception should be advised to continue contraception for at least 7 days after sterilisation. (FSRH)

Only 3 women had documented advice regarding contraception till next period.

COMPLICATIONS



WAITING TIMES

The interval between booking time to surgery time varied between 2 and 19 months.

Half of the cases waited almost 12 months to have the procedure done and this wait is extending due to the pandemic.

We currently have 50 women on our waiting list for this procedure with some continuing to breach a 100 week wait.

CONCLUSION

The quality of counselling was not consistent for cases reviewed.
The waiting time has lengthened to an average of 18 months and women have not been sign posted to alternate methods of contraception during this wait.
There is need for an improved pathway for women requesting this service.

ACTION PLAN

We are currently in consultation with the CCG and our local contraceptive and sexual health service to create a bespoke pathway for this cohort of women. This will ensure women have the highest quality of counselling, are aware of all their contraceptive options and women who are listed for surgical management have cover whilst waiting.