VASECTOMY AND REVERSAL CENTERS OF FLORIDA

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Satellite Vasectomy Service Sites:

Jacksonville	Orlando	Port Orange	Sarasota	Vero Beach
Lake City	Kissimmee	New Port Richey	Punta Gorda	West Palm Beach
Gainesville	Winter Haven	Bradenton	Ft. Myers	Aventura
Ocala	Largo	Wauchula	Naples	

GENTLE TOUCH® (NO-SCALPEL NO-NEEDLE) VASECTOMY

Vasectomy is a method of birth control chosen by more than 500,000 men each year in the United States. It is a simple, safe procedure that is more than 99% effective in preventing unwanted pregnancy. Vasectomy does not affect one's manliness in any way because it has no effect on the male hormones produced by the testes. Sex drive, the ability to attain and maintain erections, and the sensation of orgasm usually remain the same following vasectomy. Since the procedure only prevents sperm from entering the semen (ejaculate) and since sperm comprise only 2-5% of the semen volume, most men notice no change in the male reproductive fluids.

Vasectomy is performed in the office under local anesthesia and most patients agree that it hurts about as much as having a blood sample drawn from the arm, though many say not at all. Since May of 2003, I have used a spray applicator (Madajet®) to deliver a stream of anesthetic so fine that it numbs the skin and penetrates to a depth of about 3/16 of an inch, enough to surround and anesthetize each vas tube in turn as it is lifted into position beneath the skin. After cleansing and draping the scrotum in a sterile field as the anesthetic takes effect, one vas tube is manipulated back into position just underneath the area of numb skin. It is held against the skin with a special fixation forceps, then drawn through a small opening in the skin, divided, and the upper cut end cauterized so that it will seal by scarring. A small titanium clip is used to close the vas sheath around the lower end so that the ends are separated by a tissue layer and less likely to grow back together. (No, you won't set off airport alarms and your scrotum won't explode in an MRI machine.) The vas ends are released back into the scrotum and the other vas is brought out thru the same opening and treated similarly. No sutures are required; the small opening will seal within a day.

Partners are welcome to accompany patients and watch the procedure.

The patient is asked to minimize activity for 48 hours. He may return to work and normal sexual activity 2 days after the procedure.

Vasectomy reversal is a three-hour procedure that results in return of sperm to the semen about 85% of the time overall. Success rates decrease with time after vasectomy, ranging from 97% sperm recovery and 75% pregnancy within 3 years of vasectomy to 65% sperm recovery and 30% pregnancy when the interval has been longer than 15 years. Because reversal attempts are not always successful, vasectomy should be considered a permanent and irreversible procedure.

For patients who pay by cash, check or credit card, my practice charges $490.00 for the vasectomy procedure. This fee covers follow-up visits (if necessary) and semen checks in the office to be sure no sperm remain in the ejaculate. So much information is available online at www.vasweb.com and by mail (for those who do not have Internet access) that a preliminary consultation visit is not required, but I would be happy to meet personally with any patient who would like to do so prior to his procedure, and for this visit there is no charge. (I usually require separate visits or preliminary telephone consultations for childless men in their early 20's, just so they have plenty of time after the consultation visit or call to consider alternatives.) In addition, the online pre-registration process allows me to review the surgical and medical histories of each patient before the procedure so that we can speak personally by phone if I identify any issues that may be cause for concern. Unless the patient's vasectomy is being covered under Title 10 through a county health department, we require a $100 deposit to schedule a procedure. We ask that payment of the $390 balance be made at the time of the service unless the procedure is being covered under Title 10 or unless the patient has coverage through an insurance company or HMO for which we are a contracted provider. We will be happy to complete an itemized receipt so you may apply for reimbursement from an insurance company with whom we are not a contracted provider.

INSTRUCTIONS BEFORE YOUR VASECTOMY

1. **Please shave the underside of the penis and the front wall of the scrotum** on the evening before your vasectomy. Alcohol is used to sterilize a small area of scrotal skin before the Madajet is used and it can sting a bit right after a shave.
2. Use **no powder or deodorant** in the genital area on the day of your procedure.
3. No need to bring an **athletic supporter**. One will be provided.
4. Be prepared to sign the operative **consent** sheet (pages 3 & 4 below) upon your arrival in the office.
5. If possible, arrange to have someone drive you home. If you must drive yourself, a flat tire or fender bender could lead to complications. Plan to do nothing but recline at home on the evening of the vasectomy.
6. **Do not take any aspirin**-containing medication for five days **before the procedure**.
7. If your insurance company or HMO requires **authorization**, be sure to bring it or call ahead to see whether we have received it. If your procedure is covered through a county health department, call us to be sure we have received the paperwork.
8. If you have Internet access, please **pre-register** at http://www.vasweb.com/gemini/register.asp.
9. Prior to the procedure, **payment** of the $390 balance ($100 was paid at the time of scheduling) is required of those paying cash. We will bill health plans with which we have a contract, and then refund the scheduling deposit when we hear from the insurance company, less copayments and deductibles.

INSTRUCTIONS FOLLOWING VASECTOMY

1. Spend a **quiet evening** at home, reclining in bed or a lounge chair. Minimize activity.
2. You may take **acetaminophen** (Tylenol®) or ibuprofen **for** any **discomfort**. Avoid aspirin for 2 days after the vasectomy.
3. **No** need for **ice packs**.
4. On the **day after** the procedure, you may walk and drive as much as you like, but no sports, yard work, swimming, or heavy lifting. Men with non-strenuous jobs may work the next day.
5. You may remove the scrotal support and take a daily **shower** starting the morning after the procedure. Replace the scrotal support and wear it whenever you are up and around for the next 2 days, during sports for the next 7 days.
6. **Two days after** the procedure, you may return to work and regular activities wearing your scrotal support. Wait 3 days for aggressive sports like basketball and tennis.
7. It is normal to have some **discoloration of the skin** around the puncture site and sometimes in the upper aspect of the scrotum.
8. You may have **sex** 2 days after the procedure. It is uncommon but normal to have some blood in the semen for the first few ejaculations.
9. Since no stitches are needed, a **follow-up visit** is not required. You will be given Dr. Stein's home and cell phone numbers and if you have undue discomfort or any concerns, you should call the office or Dr. Stein anytime after your vasectomy.
10. Some men (about one in 20) will develop swelling and discomfort on one side, sometimes on both sides, starting anytime from 3 days to 3 months following vasectomy. This usually represents an exaggerated form of the normal **inflammatory response** necessary for sperm resorption and recycling. It is effectively managed with a 5-7 day course of ibuprofen 600 mg 3 times per day.
11. Eight weeks **and** at least 20 ejaculations after your vasectomy, return with a **semen sample** in a small container with a lid, such as a pill bottle, baby food jar, 35 mm film canister, etc. Please do not bring the sample in a condom or baggie as we will be unable to retrieve an adequate specimen and you will be asked to return with another sample in a container with a lid. The sample should be produced on the day of examination, but can be 3 or 4 hours old. You may bring the sample anytime during regular office hours (9:00 - 4:00 except on Wednesdays), and we will tell you within 5 minutes if you are sperm-free. If sperm are seen (5% chance after 8 weeks **and** 20 ejaculations), you will be asked to continue other means of birth control and to return with a second specimen in 2-3 weeks.
    Alternatively, if you are from out of town or if your vasectomy was done at one of our outfield locations, we will provide you with a **mailer** so you can send us a semen sample by mail. The container provided contains a bit of antibiotic so that the sample does not become overgrown with bacteria. Call us a week later for the results.

VASECTOMY - THE POSSIBLE COMPLICATIONS

Vasectomy provides the most effective, permanent means of surgical contraception. When compared with other contraceptives, it has one of the lowest incidences of side effects, considering that pregnancy is a side effect of alternative contraceptive failure. No deaths have been attributed to vasectomy in developed countries. Large-scale studies show that the overall incidence of complications is less than 5 per 100 vasectomies performed.

Minor side effects immediately following vasectomy may include discomfort, swelling and/or bruising of the scrotal skin, all of which usually disappear without treatment. Some men (about 1 in 20) will experience swelling and a low-grade ache in one or both testes anywhere from two weeks to six months after the procedure. This is probably due to an exaggerated form of the body's natural response to the obstruction caused by the vasectomy. It usually responds nicely to an anti-inflammatory drug (such as ibuprofen) 400-600 mg 3 times per day and almost never lasts for more than a week or two but for rare patients, fewer than 1 in 100, **swelling and discomfort** will occur more than once and/or will be severe enough to require prescription pain medications, stronger anti-inflammatory drugs, and one or more days off from work.

Early complications such as hemorrhage and infection can occasionally occur after any surgery. Based on large-scale studies, the overall incidence of either hematoma (a blood clot in the scrotum) or infection is less than 2% of the vasectomies performed. As of June 2010, I have performed over **22,000 vasectomies**. Ten patients have developed **blood clots** in the scrotum; eight did not require surgical drainage, but swelling did keep them quite tender for 2 to 4 weeks post-op; one man did require admission to the hospital and surgical drainage of the blood clot under general anesthesia in the operating room, and another required surgical drainage through a 1-2 inch incision in the office. Two severe **infections** have occurred: the patients had prolonged discomfort and progressive swelling on one side, not responsive to oral antibiotics, eventually maturing to a painful walnut-sized abscess requiring office drainage through a half-inch incision and a two-week period of local wound care. Two milder infections caused vasectomy site swelling and, in one case, even discomfort with urination, but they responded quickly to antibiotics.

Long term, vasectomy can lead to the following **conditions**:

1. A sperm **granuloma** is a pea sized tender mass which results when the body reacts to and walls off sperm which may leak from the lower (testicular) end of the cut vas. Occasionally this will be tender enough that removal is required, but most patients do not experience discomfort unless they are actually squeezing on the small mass. A sperm granuloma may enhance the likelihood of reversal success.

2. A few (perhaps 5%) of patients will experience periodic **tenderness** of the epididymis, the tube behind the testis in which sperm are resorbed by white blood cells after vasectomy. Since this resorption process is a form of inflammation, it nearly always responds to a short course (3-7 days) of an over-the-counter anti-inflammatory drug such as ibuprofen. **Post-vasectomy pain syndrome** is defined as *testicular pain (on one or both sides) for greater than 3 months after having a vasectomy, severe enough to interfere with daily activities and causing a patient to seek medical attention*. Because pain is so subjective, reported rates vary but compiled data would suggest that this is a significant problem for 1-2% of vasectomy patients. Vasectomy reversal, removal of the epididymis, or or a special procedure called neurolysis may be required to alleviate the discomfort. **Two** of my vasectomy patients have been bothered enough by low-grade discomfort on one side that they have considered removal of the epididymis on that side, **two** others have had intermittent discomfort on both sides severe enough that they underwent vasectomy reversal, and **two** others have undergone neurolysis, which is division of nerves through small groin incisions to relieve pain. Since 1983, **seven** patients have experienced prolonged **vasectomy site pain**. For one patient, the pain was so severe that he was unable to work for a month after the procedure. Six other patients had prolonged vasectomy site tenderness for which they eventually chose to undergo another vasectomy procedure on one side to remove the tender spot. Thus, out of over 19,000 patients, twelve (less than one in 1000) have considered or required a second procedure to manage pain. So it seems that the rate in my practice is lower than that reported elsewhere, perhaps because of differences in technique between surgeons, but the risk is still very real.

3. **Recanalization** is the re-establishment of sperm flow from the testis up to the rest of the reproductive tract by virtue of the cut ends of the **vas growing back together** after vasectomy. Most **early** recanalizations occur during the healing process and are detected at the time of follow-up semen checks (live sperm are seen). It obviously requires that the procedure be repeated and there is no charge for the second procedure. Up until late 1990, when we started separating the vas ends with a tiny clip, we had 3 patients with this complication out of about 1500 (1 in every 500). Since then, and of about 19,000 vasectomies, we have had another 5 early failures (**1 in every 3000**). One was in a man who presented quite a vasectomy challenge because of scarring from scrotal surgery as a baby. Three other men had live sperm on all samples checked for 6 months after their vasectomies, and a fifth had no live sperm but enough non-living sperm eight months after vasectomy that we chose to repeat the procedure. **Late** recanalization, return of live sperm to the semen at some time after the semen has been confirmed to be sperm-free by microscopic examination, is also very rare. I have had direct experience with this four times: (1) a man whose vasectomy was performed in 1988 and whose semen was sperm-free three months later got his wife pregnant in 1991 and his semen at that time showed live sperm (she never got pregnant again and he returned for a vasectomy reversal in 2005 at which time he was again sperm-free), (2) another patient whose vasectomy was performed in 2000 had no sperm in his semen two months later, but his wife became pregnant nearly 4 years later and a semen check revealed a very low sperm count, (3) a man whose wife became pregnant about 16 months after a vasectomy and negative semen check (she miscarried, so it did not result in a live birth), and (4) a man whose vasectomy was performed and whose semen was sperm-free in early 2005 got a partner pregnant in late 2006; no sperm could be found in his semen even then, but DNA tests confirmed his paternity (the veritable "one got through"). From these four cases and reports in the literature, late failure resulting in pregnancy is possible but rare, odds being **less than one in 4000**, a rate of failure much lower than with any other form of contraception. My office does not require another semen check after the absence of sperm has been confirmed, but patients are encouraged to return with or mail a second sample 4 months after vasectomy to achieve an added index of confidence; and we will examine semen at no charge on any vasectomy patient throughout his lifetime as often as he desires.

4. Antisperm antibodies do appear in the blood of about half of the patients who undergo vasectomy and patients who develop antibodies have a lower chance of causing a pregnancy even when a successful vasectomy reversal allows sperm to re-enter the ejaculate. These antibodies have no influence on health status otherwise.

5. The February 17, 1993 issue of the Journal Of The American Medical Association contained 2 studies (by the same research group) suggesting that vasectomy was associated with a small increased risk of **prostate cancer** in their study groups (almost 30,000 patients in 1 study and almost 40,000 patients in the other study). Because the question was initially raised by 2 studies back in 1990, the World Health Organization convened a 1991 meeting of 23 international experts to review all research regarding vasectomy and prostate cancer. They concluded that there was no plausible biologic mechanism for a relationship between vasectomy and prostate cancer. Some medical researchers interpreted the small increased risk noted in

the 1993 studies as a weak association that may be due to chance or bias. Many studies published since then show no relationship between vasectomy and the risk of prostate cancer. Because the question of a relationship has been raised, however, the American Urologic Association recommends that men who have had vasectomy and are over 40 have an annual rectal exam and prostate cancer screening blood test (PSA). This is the same recommendation made by the AUA for all men of age 50-70. My office has copies of these and other research studies, available to any patient upon request.

6. There are reports on the Internet in which contributors claim that they experienced a decrease in erectile function, libido, or climax intensity after vasectomy. In 2006, we mailed 400 surveys to men whose vasectomies had been done more than six months prior to the survey. One hundred nineteen (119) surveys were returned and these are the results:

Since your vasectomy, how have the following changed?	Much less	Slightly less	No change	Slightly more	Much more
Sex drive (libido)	2	4	92	16	2
Ability to obtain and maintain **erections**	0	5	110	4	0
Rigidity (stiffness) of **erections**	0	5	109	4	1
Strength of **orgasm** (climax) sensation	0	6	98	12	1
Semen volume (the amount of fluid that comes out when you ejaculate)	5	16	86	12	3

There is no physiological explanation for these changes, either positive or negative, but men should consider the slight possibility of a negative influence of vasectomy on their sexual responses.

There are a number of **alternatives to vasectomy**:

1. **Barrier methods.** You could wear a *condom*, your partner could use a *diaphragm*, or you could use *both together*.
2. **Spermicides.** There are *foams and creams* that can be placed into the vagina before intercourse to kill sperm before they can fertilize your partner's eggs. Spermicides can be used alone or in combination with barrier methods.
3. **Hormonal methods.** Your partner may use birth control *pills, shots, or patches* to prevent the release of eggs from the ovaries or the implantation of fertilized eggs into the uterus (womb). *Emergency Contraception* (EC, or the "morning-after" pill) will prevent pregnancy if taken within 72 hours of intercourse during which no contraception was used.
4. **Intrauterine device (IUD).** Your partner may have a small device placed into her uterus to decrease the likelihood of fertilization (sperm and egg coming together) and to prevent implantation of fertilized eggs into the uterus.

All of these alternatives are less effective than vasectomy, but they are reversible. You should be familiar with them before proceeding with vasectomy. Please ask us if you would like more information, and feel free to postpone your vasectomy if you need more time to evaluate information about alternatives.

There is no form of fertility control except abstinence that is free of potential complications. Vasectomy candidates must weigh the risks of vasectomy against the risks (for their partners) of alternative means of contraception as well as the risks associated with unplanned pregnancy and either induced abortion or childbirth. Vasectomy provides a means of permanent birth control with a minimum likelihood of complications and maximum chances of effectiveness and safety.

FEES

Patients who pay cash for vasectomies are given a discounted rate of $490.00 for the procedure. We will not apply for your insurance without payment at the time of the procedure unless you are a member of a health plan with whom we have a contract. Insurance carriers of patients who ask that we work with their contracted PPO or HMO are charged $600.00 because much more office work is involved, payments are often delayed, and insurance companies expect us to charge that much. Indeed, some health plans feel that $490.00 is less than the usual and customary fee for this procedure, but we want to keep vasectomy within the financial grasp of uninsured cash patients. If you have a plan which does not cover vasectomy performed by Dr. Stein, and if you have failed to determine that beforehand by checking with your carrier, and if they deny a claim made on your behalf, you will be billed $600.00. If vasectomy is a covered service through Dr. Stein but you have not met your health plan deductible, it may be to your benefit to pay cash and then submit the receipt to your plan company (so your payment can be applied to your deductible), since a deductible of $1000.00 could leave you with a bill of $600.00 if you have seen no other doctors this year. For example, if your health plan is billed $600.00, and if they approve $550.00 but you have a $1000.00 deductible, you will be asked to pay more than you would have had to pay had you come to our office as a cash patient (in this example, $550 as opposed to $490). There are so many different health plans, that we have tried to simplify our office procedure and give you these 2 options. If you have any questions, please don't hesitate to ask.

CONSENT FOR STERILIZATION

I, the undersigned, request that Dr. Douglas G. Stein perform a bilateral vasectomy, a procedure to produce obstruction of the vas deferens for the purpose of producing sterility. I understand there can be no absolute guarantee that this or any procedure will be successful. It is understood, however, that my semen will be checked following the operation. I understand that contraception must be practiced until there are no sperm present. I also understand that while the reversal success rate is quite good, it is not 100%, and vasectomy should therefore be considered a permanent or irreversible procedure. I recognize a small chance that I might have to come to Dr. Stein's Tampa office or go to the hospital for evaluation and treatment of a very rare complication. By consenting to vasectomy and accepting the risks outlined above, I release Dr. Stein from liability for time lost from work, salary unearned, and medical expenses incurred to treat complications. I also understand that only my insurance company (not even someone in Dr. Stein's office) can verify if Dr. Stein is a provider under my specific plan because provider lists change frequently as insurance companies merge and split.
I have read and understand all paragraphs of this double-sided single-spaced document.

Patient's signature ________________________________Wife's signature (optional)___________________________

Witness____Date_______________________________________

(Vasectomy info & consent.doc 6/7/10)