SUMMARY AND CONCLUSION
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The comparative evaluation of two techniques of vasectomy was carried out in M.L.B. Medical College Hospital, Jhansi from May, 1982 to April, 1983. These techniques are, a new technique percutaneous fulguration of vas and the other older one is vasectomy by open method.

In percutaneous fulguration of vas, insulated cataract knife was prepared. This insulation was done by stellon cold cure acrylic resin powder and liquid. The insulation was done on it’s blade except at it’s tip. The sterilization of the instrument was done by Gluteraldehyde (Cidex R)

The technique was first done in patients of Benign Prostatic Hypertrophy coming for definitive surgery and then in patients coming for voluntary vasectomy.

The technique of percutaneous vas fulguration was done in twenty two cases. The patient was prepared, part was cleaned and dropped. The vas was palpated and it was caught by towel clips. The vas in between two towel clips was cut and cauterized by insulated cataract knife. The area was sealed by
tincture benzoin. Similar procedure was done on opposite side. The patient was looked after for Pain, Swelling, Fever infection and epididymo-orchitis 7 to 8 days.

In cases of Benign prostatic hypertrophy, vas was removed on the day of defective surgery. The patency of cut ends was seen by saline or methylene blue injection and they were sent for histopathology. Histopathological examination of the resected segment of vas showed Hyalinization and fibrosis of the wall. The epithelium lining of the lumen of the vas showed marked proliferation and multi layering of the cell resulting in marked narrowing and occlusion of the lumen. Moderate mono nuclear inflammatory reaction was also seen around the vas.

In patients coming for voluntary vasectomy, the similar procedure was done. They were also followed up for Pain, Swelling, Haematoma, Fever, Pus formation and epididymo-orchitis for 7 to 8 days. Semen examination was done at the interval of 15 days, 1 month, 1½ months, 2 months and 3 months.

In these 22 cases, only ulceration of skin (9.06%) and haematoma formation (4.54%) was found. The failure rate was (4.54%).
In the other group, open vasectomy by standard method was done. The vas was opened and the small segment was removed and the ligation of the cut ends was done by thread or silk. The wound was closed by few stitches. The patient was for followed up for pain, swelling, haematoma, pus formation, fever and epididymo-orchitis and sinus formation. The semen

In these 10 cases only infection (20%) and sinus formation (10%) was noted. There was no failure (0%).

The new technique appeared to be very simple and with less complications as compared to open vasectomy. With further trials, the procedure may prove to be the most popular and easily acceptable to the Indian Community, since there is no open operation or stitch removal. This technique also alleviates the fear of an operation. The technique can be applied to masses in large scale family planning campaign in the field without fear of tetanus and associated morbidity.

Since small area of vas is destroyed through electrosurgical cautery as opposed to a segment of vas in open vasectomy, recanalization will be easier to perform if required at a later date.