VASECTOMY COUNSELING

Patient:_____ Date_____

PRESENT: ☐ Husband ☐ Wife Other

Counseling:
- ☐ 1. Movie seen.
- ☐ 2. Patient Information on male sterilization Booklet B given.
- ☐ 3. Explanation of male hormone, blood supply and vas roles.
- ☐ 4. Reviewed State Consent Form PM284 (7/78).
- ☐ 5. Reviewed and signed State Consent Form PM284 (12/81).
- ☐ 6. Patient Information Sheet filled out.
- ☐ 7. Pre and post vasectomy sheets given to patient.
- ☐ 8. Discussed NIH Summary regarding Vas/Ca Prostate.

P.E.:

Testes	R_____	Testes	L_____	Comments: _____
Vas	R_____	Vas	L_____	_____
Cord	R_____	Cord	L_____	_____
Hernia	R_____	Hernia	L_____	_____

Date:_____

POST VASECTOMY VISIT

Wound: Clean_____ Other _____

R hemiscrotum and cord _____

L hemiscrotum and cord _____

Comments _____

_____

_____

NAME: _____

1ST SEMEN CHECK:	DATE _____	SPERM PRESENT	_____	ABSENT	_____
PATIENT NOTIFIED:	DATE _____	SPERM PRESENT	_____	ABSENT	_____
2ND SEMEN CHECK:	DATE_____	SPERM PRESENT	_____	ABSENT	_____
PATIENT NOTIFIED:	DATE_____	SPERM PRESENT	_____	ABSENT	_____

I have received the May 26, 1993 JAMA article from the National Institute of Health Association, on " Vasectomy and Cancer of the Prostate in Future Years." _____

I have discussed with Dr. Weinberg, Dr. Gazzaniga, or Dr. Tygenhof recanalization of the vas deferens. This means that the vas can become reattached and sperm again appear in the ejaculate. This can result in pregnancy. _____

I have received a copy of the California Department of Health Services booklet entitled "Understanding Vasectomy." _____

SIGNATURE_____

DATE_____

SOUTHLAND UROLOGY

Adult and Pediatric Urology

301 W. Bastanchury Rd.,
Suite 180
Fullerton, CA 92835

16960 E. Bastanchury Rd.
Suite F
Yorba Linda, CA 92886

Day or Night Call:
(714) 870-5970

INSTRUCTIONS BEFORE YOUR VASECTOMY

1. On the night prior to your vasectomy, cut as short as possible all the pubic hair on the base of the penis and scrotum with scissors. Then, using Ivory soap (rather than any commercial shaving preparations), shave at the base of the penis and all of the scrotum (front and back). Pay particular attention to the upper one-half of the scrotum and the base of the penis, as this is the site of the incision(s).

2. The vasectomy will not be done unless the shave is performed properly.

3. Take a thorough shower prior to your surgical appointment. Use only Ivory soap.

4. BRING A JOCK STRAP OR COMPRESSION SHORTS with you on the day of the vasectomy.

5. There are no dietary restrictions either pre- or post-vasectomy. However, no alcohol should be consumed prior to your visit. A light meal is preferred pre-vasectomy if possible.

6. Have someone available to drive you home from the office after your vasectomy if possible.

7. Plan your post-operation vasectomy schedule.

8. Read the AFTER YOUR VASECTOMY INSTRUCTIONS which are attached.

9. Avoid heavy lifting, prolonged standing, or walking for at least 48 hours after the vasectomy.

10. Further instructions will be given at the time of your vasectomy. Any questions will be answered at that time as well.

SOUTHLAND UROLOGY

Adult and Pediatric Urology

301 W. Bastanchury Rd.,
Suite 180
Fullerton, CA 92835

16960 E. Bastanchury Rd.
Suite F
Yorba Linda, CA 92886

Day or Night Call:
(714) 870-5970

INSTRUCTIONS AFTER YOUR VASECTOMY

1. Read number 12 below first.

2. In general, your post-vasectomy period should be marked by modified physical activity. Your basic goal is not to increase your intrabdominal pressure (tighten your stomach muscles). This can aggravate your scrotal condition.

3. You may shower immediately after arriving home to remove the iodine from your groin area, but do not use soap. Soap may be used on the incision(s) after 24 hours.

4. Place an ice pack on scrotum after you are home; keep it on for about 4 hours.

5. A slight amount of bleeding and swelling is expected. If this becomes severe, call the office number immediately.

6. During the first 7 to 10 days, wash your scrotum and incision(s) 2 or 3 times daily and blow it dry with a hair dryer. This keeps the skin dry and healthy in a normally moist area.

7. One may resume sexual activity after 4 to 5 days. But, for two weeks, do not engage in any strenuous activity, heavy lifting or athletics such as golf, handball, yard work, weight lifting, or jogging (got the idea?). The purpose is not to increase your internal abdominal pressure.

8. For the first week, it is suggested that you wear a jock strap or compression shorts day and night. For the second week, wear your jock strap or compression shorts during the daytime only.

9. Moderate scrotal or groin pain can occur up to 4 to 6 weeks after the vasectomy. If this becomes severe or marked swelling of the testicle(s) occurs, return to be checked.

10. A small lump in the cord above the testicle may be felt on each side at the vasectomy site. This is normal and with time will get smaller.

11. Apply Neosporin or an equivalent antibacterial ointment to the incision for a few days, and then switch to Vaseline.

12. **IMPORTANT: YOU ARE NOT STERILE.** Continue to use your usual form of birth control until semen has been checked for sperm. Usually, at least 20 ejaculations are necessary before the semen is sperm-free. It is after this number of ejaculations that your semen should be checked for sperm.

SOUTHLAND UROLOGY

Adult and Pediatric Urology

301 W. Bastanchury Rd.
Suite 180
Fullerton, CA 92835
Day or Night Call:
(714) 870-5970

16960 E. Bastanchury Rd.,
Suite F
Yorba Linda, CA 92886
Day or Night Call:
(714) 870-5970

NAME_____ DATE OF BIRTH _____
Last First Middle

DAYTIME PHONE_____ HOME PHONE _____

MARRIED ◯ SINGLE ◯ NUMBER OF CHILDREN _____

		YES	NO
1.	Do you have any allergies? If so, to what? _____	◯	◯
2.	Have you ever fainted?	◯	◯
3.	Have you ever had heart problems?	◯	◯
4.	Have you ever had a convulsion or seizure?	◯	◯
5.	Do you have diabetes?	◯	◯
6.	Are you taking any tranquilizers? If so, what? _____	◯	◯
7.	Do you have both testicles?	◯	◯
8.	Have you ever has surgery on your testicles?	◯	◯
9.	Have you had a vasectomy before?	◯	◯
10.	Do you have problems with impotence?	◯	◯
11.	Are you taking phenobarbital or any barbiturates?	◯	◯
12.	Is there anything you would like to discuss privately?	◯	◯
13.	Is there anything about your general health that you feel is important and that the doctor should k n o w ? If so, what? _____	◯	◯

From the National Institutes of Health

Does Vasectomy Cause Prostate Cancer? Current clinical and public health practices regarding vasectomy should continue unchanged at this time. This is the recommendation of a panel of experts (see box) convened by the National Institutes of Health (NIH) March 1 and 2 to review all currently available information on a possible causal relationship between vasectomy and prostate cancer. Sponsors of the meeting were the National Institute of Child Health and Human Development (NICHD), the National Cancer Institute (NCI), and the National Institute of Diabetes and Digestive and Kidney Diseases.

The meeting was prompted by recent findings (*JAMA.* 1993;269:873-877 and 1993;269:878-882) of a weak positive association between vasectomy and prostate cancer in studies funded by the NICHD, NCI, and the National Heart, Lung, and Blood Institute. These studies looked at large numbers of men drawn from ongoing epidemiologic investigations.

Little is known about the etiology and pathogenesis of prostate cancer. A causal relationship, if proven, would be of great significance to individual and public health, particularly in countries like the United States, where prostate cancer and vasectomy are common. Among US men, prostate cancer is the most commonly diagnosed cancer and second only to lung cancer in cancer mortality among men. Roughly one of every five US men over the age of 35 years has had a vasectomy.

The results of past epidemiologic investigations of a relationship between vasectomy and prostate cancer have been conflicting. While the two recent reports suggest a weak positive association, results from studies presented at the meeting indicate little or no association. These included an NICHD meta-analysis of epidemiologic studies (*J Clin Epidemiol.* 1993;46:163-172); an NCI study (*Am J Epidemiol.* 1993;137:263-269); and preliminary data from a study in progress. Additional evidence was provided by updates on previously published studies (*Am J Epidemiol.* 1990; 132:1051-1055, which was supported in part by NCI, and *Cancer Causes Control.* 1991;2:113-116).

The panel concluded that the positive associations that have been found may be valid or may be because of detection bias, other sources of bias, or chance.

NIH Panel:

- Barbara Hulka, MD, MPH (cochair), University of North Carolina at Chapel Hill
- Herbert Peterson, MD (cochair), Centers for Disease Control and Prevention
- Arnold Belker, MD, University of Louisville School of Medicine
- Gerald Bernstein, PhD, MD, University of Southern California School of Medicine
- Donald Coffey, PhD, The Johns Hopkins University
- Graham Colditz, MD, DrPH, Harvard Medical School
- Jacqueline Darroch Forrest, PhD, The Alan Guttmacher Institute
- Stuart Howards, MD, University of Virginia Health Science Center
- Douglas Huber, MD, MSc, Pathfinder International
- Olav Meirik, MD, PhD, World Health Organization
- Curtis Mettlin, PhD, Roswell Park Cancer Institute
- F. K. Mostofi, MD, Armed Forces Institute of Pathology
- Amy Pollack, MD, MPH, Association for Voluntary Surgical Contraception
- James Shelton, MD, Agency for International Development

(These issues have been addressed in *JAMA.* 1993;269:913-914 and *Am J Epidemiol.* 1990;132:1062-1065.)

There is a strong potential for detection bias because much of prostate cancer is undetected and underreported. This observation, along with possible differences in the use of health care services by men who have had vasectomies and those who have not, may result in different rates of detection among the groups.

The credibility of a possible causal relationship between any disease and a particular factor is stronger if a biological mechanism is known to exist. Various possible mechanisms (*Eur J Cancer.* In press) were discussed at the meeting, but the panel concluded that no convincing biological mechanism has been found in this case.

Recommendations: All contraceptive methods carry risks as well as benefits. When making decisions about contraception, each individual or couple must be informed of and weigh the various risks and benefits in light of their particular circumstances and the risks associated with pregnancy. Vasectomy is a highly effective method of family planning with low surgical risks.

Because the results of research to date on vasectomy and prostate cancer are inconsistent, and the associations that have been found are weak, there is insufficient basis for recommending a change in clinical and public health practice at this time. Therefore, the panel recommended the following:

- Providers should continue to offer vasectomy and perform the procedure.
- Vasectomy reversal is not warranted to prevent prostate cancer.
- Screening for prostate cancer should not be any different for men who have had a vasectomy than for those who have not.

Research Recommendations: Because of potential individual and public health implications, it is important that the question of any relationship between vasectomy and prostate cancer be resolved expeditiously. Both epidemiologic and basic biologic research are needed to answer existing questions. The panel recommended the following:

- Epidemiologic analyses should address methodologic limitations in existing studies, including the concerns regarding selection and detection biases, and problems in ascertaining both vasectomy and prostate cancer status. The implications of trends in prostate cancer screening should also be addressed. Studies should include evaluating men aged 20 years or more after they have had a vasectomy.
- Biologic research should better evaluate the etiology and pathogenesis of prostate cancer in men and in animal models, the relationship between vasectomy and prostate pathology and function, and any relationship between vasectomy and prostate cancer.
- Epidemiologic and biologic studies should be integrated, where appropriate, to take advantage of the strengths of both approaches.
- Since the patterns of vasectomy use and the incidence of prostate cancer vary among countries, international as well as US-based studies should be pursued.

—by Bernadine Healy, MD,
Director
National Institutes of Health

Editor's Note: Inquiries may be directed to Bobbi Bennett, Special Assistant for Scientific Information, NIH, Bldg 31, Room 2B19, Bethesda, MD 20892; telephone (301) 496-8855.

Vasectomy and Prostate Cancer: A Case-Control Study in a Health Maintenance Organization

Kangmin Zhu,[1,5] Janet L. Stanford,[1,5] Janet R. Daling[1,5] Barbara McKnight,[2,5] Andy Stergachis,[1,3] Michael K. Brawer,[4,6] and Noel S. Weiss[1,5]

A case-control study was conducted within Group Health Cooperative of Puget Sound to evaluate the relation between prior vasectomy and the risk of prostate cancer. Cases consisted of 175 men newly diagnosed with histologically confirmed prostate cancer during 1989–1991. A total of 258 controls, matched to cases on birth year and membership status, were randomly selected from the general membership of the plan. Information was collected from mailed questionnaires and medical records on medical history, including prior vasectomy, anthropometric measures, family history of prostate cancer, personal habits, and medical care utilization, and demographic factors. Conditional logistic regression analyses showed that the odds ratio for prostate cancer associated with vasectomy was 0.86 (95% confidence interval 0.57–1.32) after adjustment for confounders. The odds ratio estimate did not differ substantially by age at vasectomy or time since vasectomy. However, the odds ratio estimate for prostate cancer associated with vasectomy tended to be increased among men who had a father or brother with prostate cancer. Nevertheless, the increased risk may be related to detection bias or differential participation rates due to both vasectomy status and a family history of prostate cancer. These results suggest no overall association between vasectomy and prostate cancer. *Am J Epidemiol* 1996;144:717–22.

case-control studies; prostatic neoplasms; vasectomy

CA CANCER J CLIN 2000:50:2-3

NEWS BRIEFS

Vasectomy Does Not Increase Prostate Cancer Risk

Results of an NCI-funded study on a potential link between cancer risk and vasectomy should prove "reassuring" to physicians who perform vasectomies, as well as to couples selecting the procedure for contraception, according to Janet Stanford, MD, lead researcher. The study, which was the largest ever conducted on this issue, was carried out by the Fred Hutchinson Cancer Research Center, Seattle, in collaboration with researchers from the University of Washington School of Public Health and Community Medicine and Seattle's Northwest Prostate Institute.

The five-year study of 1,456 men between 40 and 64 years of age compared 753 men with prostate cancer to 703 who did not have cancer. The research team determined the subjects' medical history, screening history for prostate cancer, diet, and use of vitamin and mineral supplements, as well as whether they had or had not undergone vasectomy.

Results, which were adjusted for confounding variables such as age, race, and family history of prostate cancer, showed a similar prevalence of vasectomy in the two groups: 39.4% of those with prostate cancer had undergone vasectomy compared with 37.7% of those in the non-cancer group.

According to long-time prostate cancer researcher, Gerald P. Murphy, MD, President of the Pacific Northwest Cancer Foundation and *CA*'s Editor-in-Chief, "This report is similar to several other recent studies that have failed to find an association between vasectomy and prostate cancer."

The $1.8 million NCI-supported study was reported in *Cancer Epidemiology, Biomarkers and Prevention* (1999; 8:881-886).