
EDITORIAL

Editorial Note for Contraception: Tubectomy and Vasectomy Journal

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Spandana V. Editorial Note for Contraception: Tubectomy and Vasectomy . Surg Case Rep 2021;5:1.

Tubectomy is a surgical method for purifying in which the fallopian tubes are removed or permanently sealed, which inhibits the fertilization of eggs by blocking the egg released by the ovary from contacting the uterus. It is also termed as a tubal ligation or tubal sterilization. It is examined as a long-lasting surgery for the birth control. Surgery: Case Report during this year also brought out World Congress on Otolaryngology - Head and Neck Surgery and Medical Summit and Expo on Surgery and Anesthesia and International Conference on Physicians and Surgeons, which consisted of ~ 50 abstracts.

Tubal ligation includes number of methods for blocking or removing fallopian tubes are: Postpartum tubal ligation, where a segment of fallopian tubes are removed, directly after a delivery and Interval tubal ligation, bilateral salpingectomy is a method in which both tubes are entirely removed from the uterine cornuae out to the tubal fimbriae; Bipolar coagulation, here electric current is used to burn the sections of fallopian tube, with or without the successive division of tube; Monopolar coagulation, in this method electric current is used to cauterize the tube, as well allows radiating current for further damage of the tubes; Tubal clip, in this method Filshie Clip or Hulka clip is used to block the fallopian tubes; Tubal ring (Fallope ring), here a silastic band is applied to the doubled fallopian tubes. A surgical technique for the female sterilization involves laparoscopy, hysteroscopy, micro laparoscopy, laparotomy, mini -laparotomy, and vaginal approaches.

Vasectomy is a surgical method for male sterilization in which the vasa deferentia are sealed or cut so as to prevent the fertilization by blocking the sperm entry into the urethra. Vasectomy contains various surgical approaches, although each vasectomy technique requires isolation and division of the vas and operative management of the vasal ends. It is recommended that at least 15mm vas should be removed. Although division of the vas without removal of a segment is effective when this technique is combined with other techniques for handling the vasal ends, such as thermal luminal fulguration and proximal fascial interposition. Cutting of the ends without the aid of surgical clips may leads to necrosis and sloughing of the ends, which may cause early failure. Lower incidence of epididymal congestion and sperm granuloma is shown by leaving the testicular end of the vas open. The no-scalpel approach results shorter operating time, swelling and less pain, and early recovery.

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Received: January 4, 2021; Accepted: January 18, 2021; Published: January 21, 2021



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