

Common Misconceptions About Vasectomy

This series of questions and answers was prepared by Sumner Marshall, MD

1. *Vasectomy is followed by decreased libido and possible impaired potency.*

False. Actually most men report an increase in libido, which may be due to the fact that they no longer need to worry about supporting future children. Similarly, there should be no effect on potency. Since vasectomy does not alter testicular hormonal function, there should be no physiologic impairment of either libido or potency. For this reason, thorough preoperative counseling is mandatory.

2. *Following vasectomy, there is an increased incidence of cardiovascular disease.*

False. Although some studies suggest increased levels of cholesterol in vasectomized monkeys, epidemiological studies fail to confirm this finding in vasectomized men. Indeed, one study done with medical students at exam time suggested that emotional stress itself may cause temporary elevation of blood cholesterol levels.

3. *There is evidence that vasectomies will disrupt the immunological system, resulting in an increased risk of autoimmune diseases such as multiple sclerosis, rheumatoid arthritis, and certain forms of cancer.*

False. The misconception is based on the finding of elevated sperm antibodies after vasectomy, and the assumption that this may lead to a generalized autoimmune phenomenon. While these antibodies do develop in a high percentage of vasectomized men, no evidence exists to date that they induce any autoimmune reactions characteristically associated with autoimmune diseases.

4. *Vasectomized men show a marked decrease in volume of ejaculate.*

False. More than 99% of the total volume of ejaculate comes from the prostate and seminal vesicles. Since less than 1% comes from the testes themselves, vasectomy causes no appreciable change in volume.

5. *It is safe to discontinue contraception six weeks after vasectomy.*

False. Even though no more sperm come from the testes after vasectomy, a sperm reservoir located distal to the testes must still be emptied. This discharge occurs at a variable rate, which is influenced by both the passage of time and by the number of ejaculations. A patient should not be considered sterile until a minimum of 16 ejaculations with two sperm free specimens have been produced; the last of the sperm free ejaculations should be at least four months after the vasectomy. Our findings in 200 consecutive cases of vasectomy show that frequently more than 10 ejaculations are necessary to procedure a sperm free specimen. Given the possibility (albeit rare) of spontaneous re-anastomosis (which is most likely to occur within the first two months after procedure) we advise waiting three to four months.

6. *If a woman gets pregnant a year after her husband's vasectomy, and her husband's semen shows no sperm, she must have had intercourse with another man.*

False. There is a definite possibility of the transient reappearance of sperm after vasectomy. This may be due to incorrect identification of the sperm specimen as negative and the patient as sterile, to the temporary occlusion of the ductal reservoir with subsequent release of sequestered sperm or to temporary spontaneous vassal re-anastomosis. The fact that no sperm were found at the time of the office visit does not eliminate the possibility that sperm were present in the husband's semen when the wife became pregnant. Denying the possibility of the husband's fertility may destroy the marriage.

7. *Patients should consider vasectomies irreversible.*

Partially true. Essentially, a vasectomy should not be performed if the patient and his partner have any thoughts of wanting a reversal in the future. Current surgical techniques make successful reversal possible, particularly if less than five years has elapsed since the vasectomy, and the previous surgery has not caused epididymal scarring. Nevertheless, during the initial interview patients should be advised against having a vasectomy if their childbearing plans might change.