

INFORMATION FOR PATIENTS UNDERGOING FALLOPIAN TUBE RECANALISATION

Introduction

This leaflet is intended to provide answers to common questions that you may have about fallopian tube recanalisation.

The fallopian tube recanalisation is almost certainly being done as a pre-planned procedure, in which case you should have plenty of time to discuss the situation with your consultant and the radiologist who will be doing the fallopian tube recanalisation, and perhaps even your own GP. Do make sure that you have had sufficient explanation about what is involved before you sign the consent form.

What is fallopian tube recanalisation?

Normally, eggs produced by the ovaries pass down fine, narrow tubes called ovarian or fallopian tubes, to reach the womb, or uterus. If either or both of these tubes are blocked, then the chances of becoming pregnant are very reduced. Sometimes the blockage may only be a plug of mucus, which can be flushed out by passing a very fine plastic tube, called a catheter, through the neck of the womb and then into the fallopian tube. This procedure is known as fallopian tube recanalisation.

Why do I need fallopian tube recanalisation?

Other tests will have shown that one or both of the tubes leading from your ovaries to the uterus have become blocked. This may well be preventing you from conceiving. It is possible that you may require an operation to try and unblock the tubes, but fallopian tube recanalisation may be all that is necessary.

Who has made the decision?

The doctors in charge of your case, and the radiologist doing the fallopian tube recanalisation will have discussed the situation, and feel that this is the best treatment option to start with. However, you will also have the opportunity for your opinion to be taken into account and if, after discussion with your doctors, you do not want the procedure carried out, then you can decide against it.

Who will be doing the fallopian tube recanalisation?

A specially trained doctor called a radiologist. Radiologists have special expertise in using x-ray equipment, and also in interpreting

the images produced. They need to look at these images while carrying out the procedure.

Where will the procedure take place?

Generally in the x-ray department, in a special "screening" room, which is adapted for specialised procedures. It may be done in an operating theatre, using mobile x-ray equipment.

How successful is fallopian tube recanalisation?

The success of the recanalisation depends upon where and why the tube is blocked. Generally speaking, blockages of the tube near the womb are more successfully treated. Here there is approximately an 80% chance that the tube can be unblocked. Unfortunately, some of these blockages recur over the next few months. It has been estimated that if the tube is successfully unblocked, then you have a 30% chance of achieving a pregnancy.

How do I prepare for fallopian tube recanalisation?

Fallopian tube recanalisation is only carried out in the first part of your menstrual cycle, once your period has stopped. If you have irregular periods, it may be best to discuss the timing of the procedure with your doctor and the x-ray department.

The procedure will probably be done as a day case, with you coming to hospital in the morning and being allowed to go home in the evening. You will probably be asked not to eat for four hours beforehand, though you may be told that it is alright for you to drink some water. You may receive a sedative to relieve anxiety. You will be asked to put on a hospital gown.

If you have any allergies, you must let your doctor know. If you have previously reacted to intravenous contrast medium, the dye used for kidney x-rays and CT scanning, then you must also tell your doctor about this.

What actually happens during fallopian tube recanalisation?

You will lie on the x-ray table, generally flat on your back. You need to have a needle put into a vein in your arm, so that the radiologist or a nurse can give you a sedative or painkillers. Once in place, this needle does not cause any pain. You may have a monitoring device attached to your chest and finger.

The radiologist will keep everything as sterile as possible, and may

wear a theatre gown and operating gloves. The procedure will start in the same way as an internal examination, with the radiologist examining you and then placing an instrument called a speculum into the vagina. This will hold the vagina open so that the procedure can be carried out. The cervix will be cleaned with antiseptic, and may be numbed with local anaesthetic.

The radiologist will then place the fine plastic tube, called a catheter, through the neck of the womb into the uterus itself. Some special x-ray dye, called contrast medium, may be injected down the catheter at this stage to show where the fallopian tubes enter the uterus. Then a very thin wire is placed through the catheter and guided into the fallopian tubes, to try and unblock them. Once the fallopian tubes have been cleared the catheter and the wire are removed.

Will it hurt?

You may feel some discomfort in the pelvis, like a period pain, when the fallopian tubes are being cleared. There will be a nurse, or another member of clinical staff, standing next to you and looking after you. If the procedure does become uncomfortable for you, then they will be able to arrange for you to have some painkillers through the needle in your arm.

How long will it take?

Every patient's situation is different, and it is not always easy to predict how complex or how straightforward the procedure will be. It may be over in 20 minutes, or very occasionally it may take longer than 60 minutes. As a guide, expect to be in the x-ray department for about an hour altogether.

What happens afterwards?

You will be taken back to your ward on a trolley. Nurses on the ward will carry out routine observations, such as taking your pulse and blood pressure, to make sure that there are no problems. You may experience a little bleeding, from where the catheter has been through the cervix. You may also experience some period type pain, although this should respond to aspirin or paracetamol. You will generally stay in bed for an hour or so, especially if you have had sedation.

What happens next?

Once you have recovered from any sedation, you should be able to go home. You can return to normal activities, including sexual intercourse, the following day.

What are the risks or complications?

Serious complications during the procedure are rare. There is a small risk of infection, which can generally be treated with antibiotics. The main complication is the possibility of a pregnancy occurring within the fallopian tube rather than within the womb. This risk is estimated at 3%. The doctors looking after you will be aware of this risk and will keep an eye on you. It is important that, having had this procedure, you contact your doctors within X days of missing a period.

Finally...

This leaflet should have answered some of your questions,

but remember that this is only a starting point for discussion about your treatment with the doctors looking after you. Make sure you are satisfied that you have received enough information about the procedure, before you sign the consent form.

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