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Letters to the Editor

**Probability of pregnancy after sterilization:
a comparison of hysteroscopic versus
laparoscopic sterilization**

To the Editor:

An illuminating paper and good that it promotes “perfect” and “typical” use failure rates for sterilizations [1]. The authors claim that they started the Markov analysis (see their Fig. 1) with “Desires sterilization”. Incorrectly so: that would be a far more complicated intention-to-be-sterilized model. Instead, their simulation starts when all sorts of barriers have already been conquered: inertia, deferment, fear, urban legends, finances, patriarchy, culture, transport, waiting lists, civil war, regulations, religion of provider or institution [2], negotiations with employer, insurer and babysitter. These obstacles have a much larger impact on the overall number of unintended pregnancies than disparities in tubal occlusion (TO) methods, however important those are for the individual women/families. For Medicaid beneficiaries, just one of those barriers — government regulations — results in 10,000 abortions and 19,000 originally unintended births annually in the US [3]. If Essure provision would remove a few of those barriers much better than access to laparoscopic TO does, then the factor 4 difference over 10 years in typical failure rates will be more than offset. It sometimes works like that in the Netherlands. More often however, the mere availability of the Essure method causes unintended effects. In abortion clinics, relevant women are enthusiastically informed about Essure as one of their options. At that time, some embrace the idea, but later, the above barriers kick in. This might result in more unintended pregnancies than combining the suction curettage with an intrauterine device insertion, for which, at that time, the hurdle is quite low. Similarly, Dutch cesareans are rarely combined with effective, convenient, very low failure, cost-free TO partly because TO deferment is often advised with the “there is this smart new technique” argument [4]. However, women are not informed about the much, much higher failure rates when compared on an intention-to-be-sterilized basis [4].

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**Probability of pregnancy after sterilization: a
comparison of hysteroscopic versus
laparoscopic sterilization: in reply**

To the Editor:

We thank Dr. Verkuyl for his interest in our paper [1] and endorsement of our recommendation to account for “typical” versus “perfect” use sterilization failure rates. We commend Dr. Verkuyl for raising additional issues that often plague women seeking sterilization, albeit these issues arise before women can choose their procedure. Our analysis begins with women choosing between two interval sterilization procedures and follows various clinical outcomes. For women with good access to both procedures, we believe that this information is vital to women and their physicians discussing the benefits and risks of these options.

We respectfully disagree with the hypothesis that if hysteroscopic sterilization provision could remove more barriers than laparoscopic sterilization, the impact would offset the difference in unintended pregnancies we calculated between the two approaches. There is no evidence to suggest that hysteroscopic sterilization is considerably better in removing the barriers Dr. Verkuyl described (inertia, deferment, etc.) than laparoscopic sterilization. In fact, our model demonstrates that the opposite is true. The need for follow-up evaluation, an extra step that could magnify some obstacles such as deferment and transportation issues, that weighs heavily among factors that affect lower overall effectiveness of

hysteroscopic sterilization. Additionally, many barriers described by the author are associated with both procedures. For example, government regulations apply to all methods of sterilization and therefore should not be different for hysteroscopic versus laparoscopic sterilization in the US [2].

The most important issue to understand from a decision analysis such as ours is the effectiveness of a procedure in a population, not just the theoretical efficacy. When women already have so many barriers to overcome, we need to ensure that information about a sterilization procedure's effectiveness is transparent and clear.

Sincerely,

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