Updated Vasectomy Guideline (2026) The Role of the APP

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APP Program Agenda
American Urological Association
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Disclosures

- Consultant to Roman Health, Posterity Health, IXYGOS, Granata Bio, Theralogix, ReproNovo, Basilea, Legacy, Abbvie, Y-Reproductive Technologies

➢No conflicts related to vasectomy except Legacy (mail-in kits)

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Learning Objectives

- Employ key elements of pre-vasectomy counseling, post-vasectomy follow-up and techniques of vasectomy that are most effective.

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Vasectomy

- Vasectomy is one of the most commonly-performed outpatient procedures in Urology
- 21% of men with one or more children, aged 44-49 have had a vasectomy
- Increased interest and demand for vasectomies in the current medical and political landscape
- White males 3 to 4-fold more likely to have a vasectomy than Hispanic or Black males
- College-educated men almost 10-fold more likely to have a vasectomy than men with only high school education
- Vasectomy is the safest and most reliable method of male contraception

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Vasectomy Guideline

Vasectomy: AUA Guideline (2026) Part I

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- Standard evidence-based AUA process for guidelines
- Key questions identified relevant to vasectomy procedure
- Additional exploration for association of vasectomy with other medical conditions

Schlegel et al., J Urology 215: 240-9, 2026

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What is new for vasectomy?

- Shifting demographics for vasectomy requests
- Data on occlusive techniques
- PVSA (Post-Vasectomy Semen Analysis) testing
- Fertility following vasectomy

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Vasectomy

- Key roles for APPs:
  - pre-vasectomy counselling
  - post-vasectomy followup
  - procedure (credentialled practitioners)

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Vasectomy demographic changes

Dobbs v Jackson 2002 Supreme Court Decision

- Vasectomy requests increased more than 150%
- Tubal ligation up even more
- More men under 30 requesting vasectomy
- Childless requests doubled (17% of all vasectomy patients)

Bole et al. Int J Impot Res. 36:265, 2024

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Pre-vasectomy counselling

- Vasectomy intended to be permanent form of contraception
- Vasectomy does not provide immediate sterility
- Contraception needed until PVSA (post-vasectomy semen test)
- Vasectomy not 100% effective (1 in 2,000 after neg PVSA)
- Repeat vasectomy needed in up to 1% of cases
- Fertility options after vasectomy: VV, sperm retrieval-IVF
- Hematoma/infection: 1-2%

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Pre-vasectomy counselling

- Chronic scrotal pain: 1-2% after vasectomy
- Other forms of contraception (temporary, permanent) exist

For men at higher risk of surgical regret re: vasectomy

- Sperm cryopreservation may be discussed

Vasectomy is not associated with risk of sexual dysfunction or change in ejaculation

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Vasectomy vs. Tubal ligation

Failure rates for permanent contraception

Open & Lap tubal ligation

- 2.9% at 1 year
- 8.4% at 10 years

Tasset et al., NEJM Evid, 3: EVIDe2400263, 2024

Vasectomy failure rates

- 0.1-1.1% at 2-5 years
- Vasectomy is the safest and most effective intervention for permanent contraception

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Case scenario 1

- 25-year-old unpartnered male with no children is interested in vasectomy as a permanent form of contraception
  - ➢Average age of fatherhood in US: 31 years

Additional considerations during counselling?

- Discussion of permanence of procedure
  - ➢Despite potential for reversal/sperm retrieval
- Regret from future partner desire/interest in having children
- Potential for sperm banking prior to the procedure

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Case scenario 2

A 58-year-old male is newly partnered with a 36 yo female partner. Both the patient and his partner have 2 children each from prior relationships and do not desire additional children. The patient is healthy and reports a strong family history of prostate cancer (father, paternal grandfather).

Key elements of counselling?

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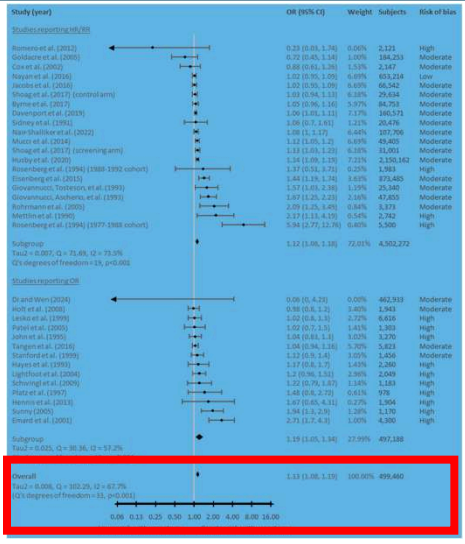
Prostate cancer after vasectomy

Overall risk of prostate cancer after vasectomy:
OR= 1.13 (1.08 – 1.19)
4.5% risk after vasectomy vs. 4.0% baseline risk

Vasectomy & high-grade prostate cancer (>7)
OR = 1.01 (0.92 – 1.11)
Vasectomy & prostate cancer mortality
OR = 0.99 (0.92 - 1.07)

No biologically plausible reason for vasectomy to cause prostate cancer



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Other risks of vasectomy

- No causal link between vasectomy and subsequent development of cardiovascular disease
- No causal link between vasectomy and risk of nephrolithiasis
- Men who have vasectomy are different from general population
  - ➢Take better care of their health
  - ➢More commonly white
  - ➢Middle/upper class

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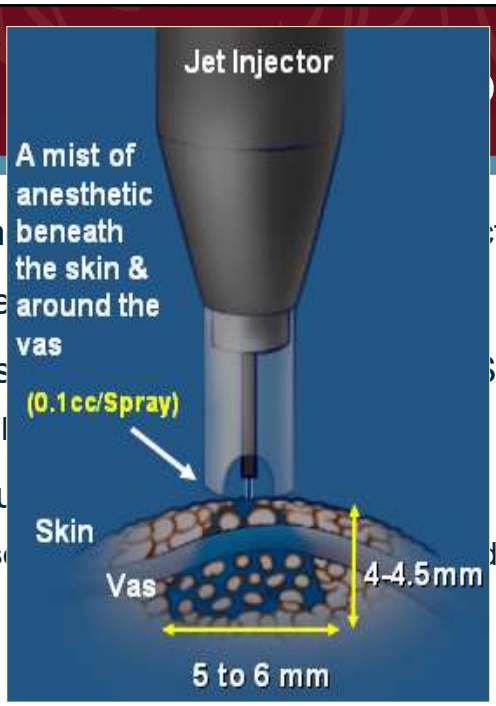
nsiderations

- Antibiotics are n tomy procedure
- Skin prep neede of surgeon
- Non-opioid anes AIDs) used
  - ➢Narcotics shoul
- Anesthesia shou
  - ➢May include us dure



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Surgical approach to vasectomy

- Incisional approach
  - Exploration of scrotum to isolate the vas deferens
  - May involve one or two incisions
  - Associated with higher risk of bleeding/infection
- Minimally invasive approach
  - Small (<10 mm) opening in the skin with minimal dissection
  - May involve several different approaches
  - Common approach: No-scalpel vasectomy

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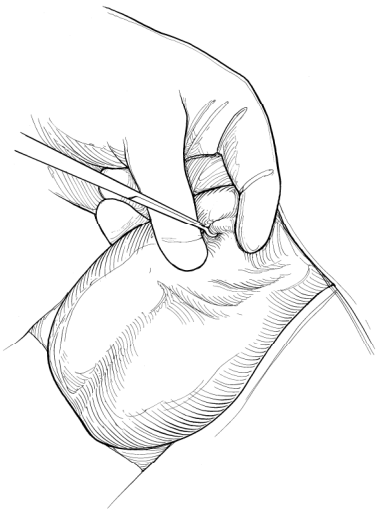
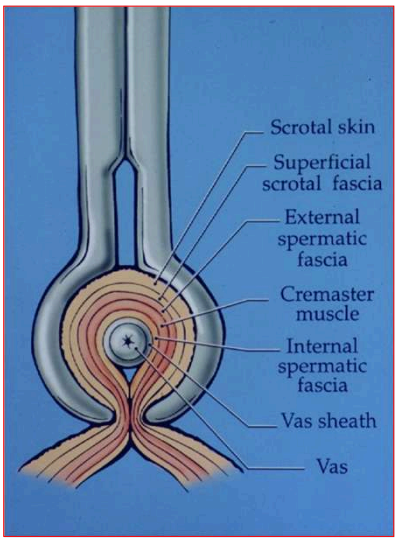
Minimally invasive approach: NSV





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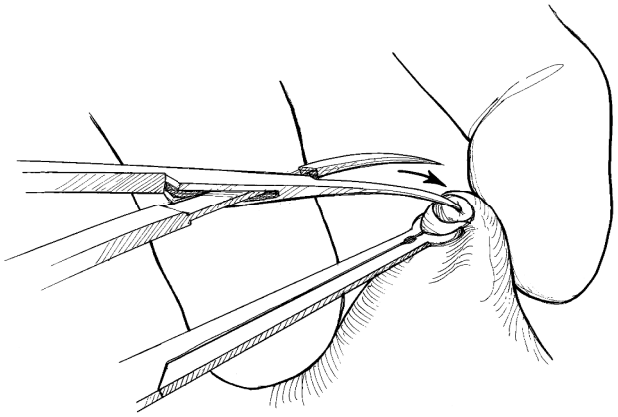
Minimally invasive vasectomy: NSV



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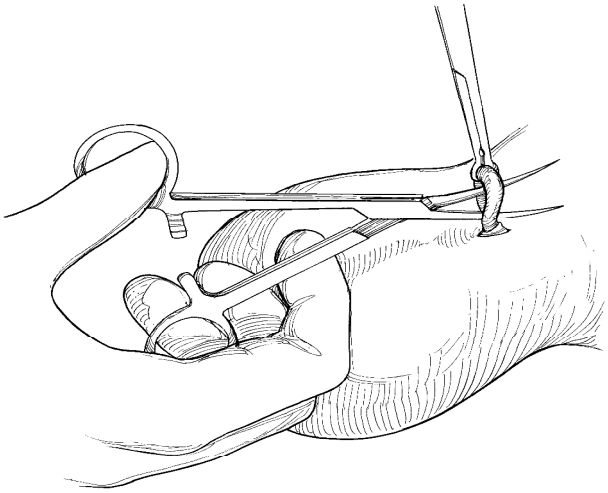
Minimally invasive vasectomy: NSV



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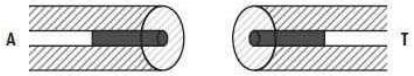
Management of the vas deferens

1. *Ligation (Suture or Clip) + Excision*

2. *Mucosal Cautery without Fascial Interposition (FI)*



3. *Mucosal Cautery (1 or 2 ends) with FI*

4. *Other Techniques/Combination*

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Vas occlusion technique

Vasectomy guideline statement 12

Surgeons should perform vasectomy with an occlusive technique that combines mucosal cautery and fascial interposition. (Strong Recommendation; Evidence Level: Grade B)

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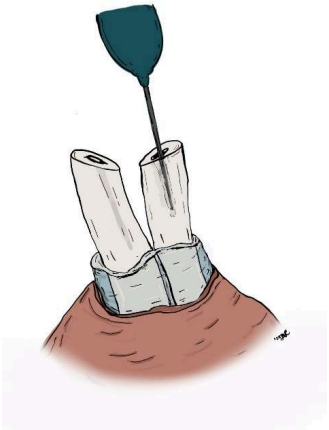
Mucosal cautery (thermal/electrical)

Thermal cautery (handheld)



Electrical cautery (needlepoint)

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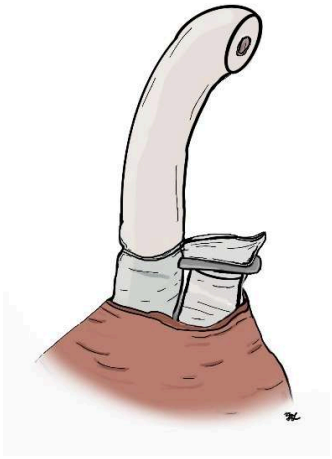
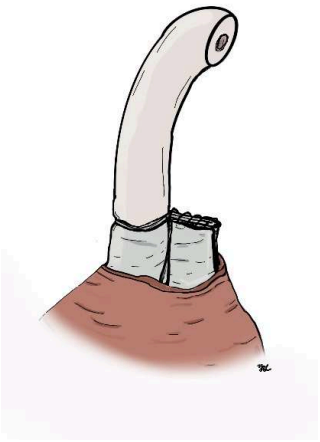
Fascial interposition techniques



Clip occlusion



Running suture occlusion

Tie/suture occlusion

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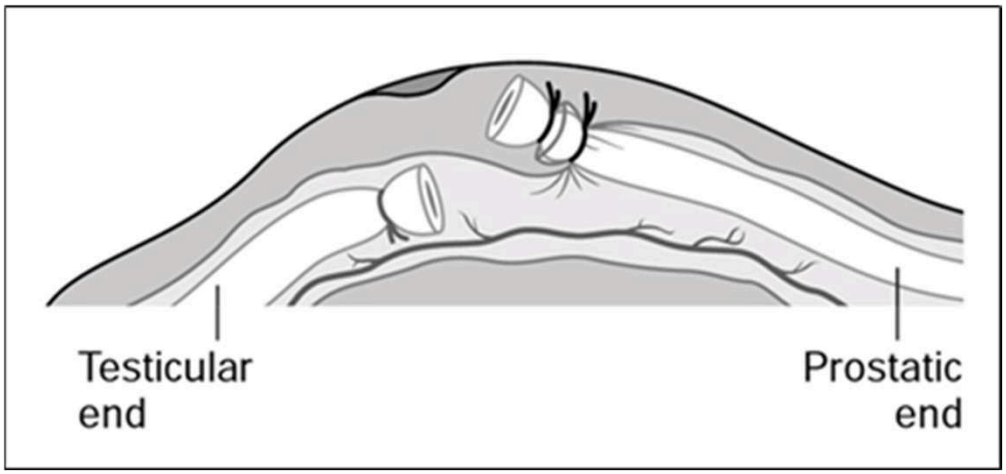
Fascial Interposition



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Post-Vasectomy Followup

- Post-vasectomy semen analysis is an important component of peri-procedural care for vasectomy patients
- Men are not immediately rendered sterile after vasectomy
- Guideline: Patients should provide at least 1 semen sample following vasectomy to confirm occlusive success
  - May be as early as 8 weeks after vasectomy
  - May be in-office/lab or male-in kit
- Success: contraception can be stopped
  - Azoospermia or
  - <100,000 non-motile sperm/mL

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Repeat vasectomy

- Persistent motile sperm in ejaculate >6 months after vasectomy
- If >100,000 sperm/mL >6 months after vasectomy
  - Shared decision-making for repeat vasectomy or further observation
  - Sperm concentration should be progressively decreasing after successful vasectomy
- Mail-in kit evaluations
  - Motility decreases during transport
  - Only azoospermic specimens considered reliable >2 hours after ejac
  - Based on uncentrifuged analysis

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Summary

- Vasectomy is a safe and effective form of contraception
- Counselling before procedure should be complete & documented
- Minimally invasive approach recommended
- Mucosal cautery & fascial interposition are best practices
- Post-vasectomy semen analysis important starting at 8 weeks
- Risk of prostate cancer because of vasectomy irrelevant
- Vasectomy reversal reviewed in an accompanying guideline publication

Schlegel et al., J Urology 215: 250-5, 2026

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