Afr. J. Med. Med. Sci. (2017) 46, 127-129

Bilateral tubal ligation in a nulliparous woman – a case report

TAO Oluwasola and OA Roberts
Department of Obstetrics and Gynaecology, College of Medicine, University of Ibadan, Ibadan, Nigeria

Abstract
Infertility is viewed in diverse ways in our environment with couples often attempting various options of treatment. Thus, voluntarily opting to remain childless has little or no socio-cultural approval and is often perceived to be an indication of covert disability. Commonest indication for bilateral tubal ligation (BTL) in our environment is completion of family size and in situations where further pregnancies will jeopardize maternal health. We present a case of a married 41 year old nulliparous woman who requested for BTL on religious ground. The couple had opted for voluntary childlessness and had been on other forms of contraceptives all through their twelve years of marriage. This is to highlight the fact that there exist in our society a small number of couples who wish to be childless and should not be denied that right after thorough counseling.

Keywords: *Infertility, disability, pregnancy, nulliparous, childless.*

Résumé
L'infertilité est considérée de manièresdiverses dans notre environnement avec des couples essayant souvent divers options de traitement. Ainsi, le fait de choisir volontairement de rester sans enfant a peu ou pas d'approbation socioculturelle et est souvent perçu comme une indication d'incapacité cachée. L'indication la plus courante pour la ligature des trompes bilatérale (LTB) dans notre environnement est la terminaison de la grandeur de la famille et dans les situations où d'autres grossesses mettent en danger la santé maternelle.
Nous présentons un cas d'une femme nullipare casée de 41 ans qui a demandé pour LTB sur un fondement religieux. Le couple avait opté pour l'absence volontaire d'enfants et avait été sur d'autres formes de contraceptifs tout au long de leurs douze années de mariage. Il s'agit de souligner le fait qu'il existe dans notre société un petit nombre de couples qui souhaitent être sans enfants et ne doivent pas être nié de ce droit après un conseil approfondi.

Mots-clés: *Infertilité, impotence, grossesse, nullipares, sans enfant.*

Correspondence: Dr. Timothy A.O. Oluwasola, Department of Obstetrics and Gynaecology, College of Medicine, University of Ibadan, Ibadan, Nigeria. E-mail: sesanoluwasola@yahoo.com

Introduction

Childlessness is regarded in many different ways in our society, at best as a misfortune, at worst as irresponsibility or deviance. Voluntary childlessness has yet to gain wholehearted social approval, and is often acknowledged as indicative of covert disability [1]. However, over the past few decades, public attitudes toward childlessness appeared to have become more accepting in some cultures [2].

Demographic characteristics, cultural and religious beliefs, and economic and education levels of the female population have been demonstrated to affect the choice of a contraceptive method [3]. Barrier methods are common with younger age group while tubal sterilization was preferred by the elderly population [3,4].In addition, high parity is an important factor choosing sterilization as nearly 90% of the sterilized women were found to have had more than 3 parous experiences [5,6]. This implied that most women had 2 reasons for wanting sterilization – no desire to have children and dislike for other contraceptives as either unsafe or ineffective [7,8].

Voluntary childlessness, on the other hand, refers to a couple's decision to delay child-bearing or not to have any children at all. There are various factors associated with a woman's likelihood of being voluntarily childless. Education, race, ethnic group and marital status have been implicated as plausible reasons for choosing voluntary childlessness. Citing religious ground as the main reason for opting to be voluntarily childless despite being married is alien to our environment.

The aim of this report is therefore to make practitioners aware of this indication for sterilization.

Case presentation

A 41 year-old nulliparous married lady presented in our facility, accompanied by her husband, with a request for bilateral tubal ligation. She is a pharmacist who had been married for 12 years but was never interested in getting pregnant. She had experienced adverse effects from some of the contraceptives used in the past including oral contraceptive pills and IUDs. As at the time of presentation, she was inconsistently using barrier methods of contraception. The couple had opted to be childless voluntarily and requested for the procedure on religious grounds (they were going to

live in the seminary for the rest of their lives). They were counseled on the implication of their choice including irreversibility and possible complications of the procedure while available options such as long acting reversible contraceptives and vasectomy as well as possibility of regrets were also discussed. The coupled were advised to take some time and consider their decision but returned to the clinic after a week and insisted on proceeding with BTL as they did not want other forms of contraception. In the presence of a second gynaecologist and a public health nurse, they both signed the consent form for the operation. She subsequently had minilaparotomy bilateral tubal ligation, using the modified Pomeroy technique, under local anaesthesia. Procedure was well tolerated and subsequent follow up was uneventful.

Discussion

The state of being childfree has been described as one borne out of a conscious decision not to have children. It has also been described as voluntary infertility implying that the couple chose to remain childless for reasons best known to them. Some couples deliberately delay child-bearing and remain childless for a certain period of time after which they proceed to have or adopt a limited number of children. On the contrary, some other couples voluntarily remain childless all through their marriage.

Different socio-demographic factors have been associated with voluntary childlessness with significant ones being education, race and marital status. Although a stable career increases the likelihood of remaining childless among women, it increases the likelihood of entering fatherhood [9,10]. Educational attainment increases the likelihood of remaining childless among women only and well–educated women are still among the most likely never to have had a child. According to a report by Livingston et al, a notable exception to the overall rising trend was observed in 2008 when only 24% of women ages 40-44 with a master's, doctoral or professional degree had not had children, a decline from 31% in 1994 [2].

When race and ethnicity are considered, white women are least likely to have borne a child and more likely to choose voluntary childlessness. However, over the past decade, childless rates have also risen more rapidly for black, Hispanic and Asian women thereby narrowing the racial gap [11]. In terms of marital status, women who were never married are most likely to be childless as would be expected but their rates have declined over the past decade, while the rate of childlessness has risen for the so-called ever-married — those who are currently married or were married at a point in time [3,11].

There are no absolute contraindications to sterilization of men or women, provided that they make the request themselves, are of sound mind and are not acting under external duress [12]. A comprehensive history should be taken and an examination should be conducted on all patients requesting sterilization. Counseling and advice on sterilization procedures should be provided to women and men within the context of a service providing a full range of information about and access to other long-term reversible methods of contraception. This should include information on the advantages, disadvantages and relative failure rates of each method. All verbal counselling must be supported by accurate, impartial, printed or recorded information (in translation, where appropriate and possible), which the person requesting sterilization may take away and read before the operation [12]. Post tubal ligation regrets are uncommon in carefully selected patients [6] and a review of 35 women showed that there was no significantly higher rate of regret in nulliparous women undergoing tubal ligation than that seen in studies of parous women [13].

In this case, the couple never wanted to have any child and hence resorted to using different types of contraceptive devices with unsatisfactory experiences, thereby necessitating her request for sterilization. After due counseling on the implication of her request and the possible alternatives especially vasectomy, she remained adamant on her choice for sterilization. Post-operatively, she was followed up for one year with no evidence of regret. It is thus pertinent to note that previously unidentified factors such as religious obligations can play a significant role in taking decisions for permanent sterilization.

However, there are certain communities and individuals with long established religious, cultural and sometimes emotional objections to sterilization and other forms of contraception [12]. Involving a mental health expert or a clinical psychologist in the counseling process will go a long way in ensuring that the patient is in the best frame of mind, thereby reducing the incidence of post BTL regrets. Even though we were unable to adopt this approach, our patient remained free of regrets one year after the procedure. Psychosocial and religious issues should, therefore, not be overlooked or given less consideration than medical issues and should constitute part of comprehensive pre-sterilization counseling.

References

1. Monach JH. Childless: no choice. The experience of involuntary childlessness. Routledge London and New York: Taylor &Francis e-Library, 2003.
2. Livingston G and Cohn D. Childlessness up among all women; down among women with advanced degrees.Pew Research Center's Social & Demographic Trends Project 202.419.4372 (2010). Available at http://pewsocialtrends.org. Accessed 18th October, 2016.
3. Kahraman K, Göç G, Taþkýn S, *et al.* Factors influencing the contraceptive method choice: a university hospital experience. J Turkish-German Gynecol Assoc. 2012; 13(2): 102 – 105.
4. Daniels K, Daugherty J, Jones J and Mosher W. Current contraceptive use and variation by selected characteristics among women aged 15–44: United States, 2011–2013. National health statistics reports; no 86. Hyattsville, MD: National Center for Health Statistics. 2015. Accessed 18th October, 2016.
5. Frost JJ and Darroch JE. Factors associated with contraceptive choice and inconsistent method use, United States, 2004. Perspect Sex Reprod Health. 2008;40(2):94–104. doi: 10.1363/4009408
6. Roberts AO and Obajimi GO. An audit of interval female sterilisation by minilaparotomy at the University College Hospital, Ibadan, Nigeria. J Obstet Gynaecol. 2013; 33(4): 403-5. doi: 10.3109/01443615.2013.769503..
7. Poston DJ and Cruz C. Voluntary, Involuntary and Temporary Childlessness in the United States [Internet]. Available at iussp.org. 2010. p. 1–35. Accessed 18th October, 2016.
8. Lidenmayer JP. Handling sterilization requests of nulliparous patients. Ob Gyn News. Jan 1, 1978; 13(1): 36 – 37.
9. Keizer R, Dykstra PA and Jansen MD. Pathways Into Childlessness: Evidence of gendered life course dynamics. J Biosoc Sci. 2008; 40(6): 863 –878.
10. Abma JC and Martinez GM. Childlessness among older women in the United States: Trends and profiles. J Marriage Fam 2006; 68(4): 1045–1056.
11. Hollander D. Women who are fecund but do not wish to have children outnumber the involuntarily childless. Perspect Sex Reprod Heal. 2007;39(2):120.
12. Royal College of Obstetricians and Gynaecologists. Male and Female Sterilisation – Evidence-based Clinical Guideline Number 4. 2004. 1-114
13. Benjamin L, Rubinstein LM and Kleinkopf V. Elective sterilization in childless women. Fertil Steril. 1980; 34(2): 116–120.