In this article we will share the experience of Dr. Andrew Kellerman and his use of the Filshie Clip for female sterilization procedures. Dr. Kellerman comments on this system and how it helps him perform easier, more reliable and safer tubal ligations.

Dr. Andrew Kellerman

Dr. Kellerman has been a practicing ObGyn for over 20 years after completing his medical training at the University of Pittsburgh School of Medicine and his residency at Western Pennsylvania Hospital. He is currently part of Magee Womencare Associates in Monroeville, PA and is affiliated with Magee-Womens Hospital of UPMC and UPMC at Daugherty Drive.

Dr. Kellerman, how long have you been in practice?

Coming up on 22 years in private practice.

How long have you been at Magee-Womens Hospital?

I moved to Magee-Womens in 2004. Prior to that, I was at Forbes Hospital for 16 years.

What are the primary surgical procedures you perform on a regular basis?

Tubal ligations, hysterectomy, exploratory laparoscopy, vaginal hysterectomies, bladder repairs, OB associated deliveries, C-sections and vaginal deliveries.

Are there any particular areas of obstetrics and gynecology that you specialize in or focus on more than others?

I take more of a general approach. If I get patients with oncology concerns, I refer them to the appropriate specialist.

When you have women coming into your practice asking about female sterilization, what types of questions do they ask and how do you review the options with them?

Well, the first thing I speak with them about is to make sure they want the procedure done. You should go into it, of course, with the idea that it is permanent. There’s always the issue of the patient having regret. I try to address that. Then, I present them with the range of options for female sterilization. If they’re not sure, I tell them, “Well, why don’t you think about it and come back later, and we can go over reversible means?” If they are absolutely sure, then I talk about three options: vasectomy for the husband, laparoscopic tubal sterilization (or if they’re pregnant at the time, postpartum sterilization) and hysteroscopic sterilization.

With regard to those women who are pregnant and inquiring about sterilization, what percentage, would you say, consider the elective interval type of procedures versus postpartum?

In my practice most are interval—easily 90% are interval—whereas 10% or less are postpartum.
What type of patients are ideal candidates for the Filshie Clip?

Ideal candidates are women who want permanent sterilization that is effective immediately. In contrast to hysteroscopic tubal occlusion, sterilization with the Filshie Clip in most cases is effective immediately and no hysterosalpingogram is required.

Have you seen the volume or demographics of your patient population change in the last few years in comparison to several years ago?

Some patients are women who are having children a little later in life as opposed to the younger demographic of twenty years ago, but overall, probably not much of a change. As my practice ages with me, I suppose I have more patients in the 50+ range compared to twenty years ago, when I first

What is the average age of those patients inquiring about female sterilization?

For permanent sterilization, I’d say most of the women are in their thirties and forties having the procedure done. I do get younger patients in their twenties, say, that already have children, and they have medical problems that another pregnancy could exacerbate, who want the procedure done. Generally, however, most patients seeking sterilization are in their thirties and forties.

Are there any overriding thoughts or concerns the patient may have about the type of procedures that you recommend?

Well, that’s where we evaluate the pros and cons of the Essure versus the Filshie Clip. People like the idea of no incisions and a procedure that can be performed in-office. Some of the cons to the Essure® may be that the patients consider it somewhat new, and so they have some apprehension towards having the procedure performed. Additionally, many of the patients don’t like the idea of having to use contraception for the first three months following the Essure procedure prior to the required hysterosalpingogram. The women who choose the laparoscopic tubal procedure just want to go in, have it done, and that’s it.

What are the key criteria that you use when determining the method of female sterilization? Are there two or three factors that you base your decision on, and do those factors influence the method you use with a certain patient?

For the vast majority of patients, I let them choose. If they are morbidly obese, however, and have a high chance of having a lot of adhesions or with a history of past pelvic inflammatory disease that I’m uncertain about, I may steer them more towards the Essure sterilization. Beyond that, if the patient isn’t a candidate for general anesthesia, I would do the Essure. For the vast majority, though, I try to present an unbiased presentation of the different methods and then let the patient tell me what they want.

What are some key aspects of counseling that you provide to patients who’ve chosen the laparoscopic tubal procedure?

Well, the biggest issue is possible regret. You know if the patient is older, in their thirties and forties, and already has children, then there’s a very low incidence of regret. Someone in their twenties, say, who may want more children if circumstances in their life change, I might be hesitant to perform a permanent sterilization. There are reversible means just as effective as the tubal. If there is any doubt about permanent sterilization I’ll do a reversible means on someone younger, and give them the option to think about the permanence of the procedure for several months, and if they still want to do it four months from now, a year from now, then we can arrange for permanent sterilization. My patients are adults; they’re capable of making their own decisions.

On average, how many sterilization procedures do you perform on a monthly basis?

I would have to say eight is a reasonable guess. Between six and eight.

When were you first introduced to the Filshie Tubal Ligation System and how did you decide to start using it?

I’m pretty sure it was in the mid 1990’s. One of the representatives came to our office and provided a demonstration using a foam uterus. It seemed reasonable to me and so I tried it. Initially, I used electrocautery and cut the tubes, but that had a higher failure rate, as verified by the CREST study. I then started using the Falope rings, which had a double bander and had a situation where the rings wouldn’t deploy. I had a few cases where I put it on and it tore the mesosalpinx, and a hematoma developed that needed to be repaired. I was dissatisfied with my experience with it, and so when I was introduced to Filshie, it just seemed so easy.
So from that point on, you’ve been using the Filshie Clip as your primary method of female sterilization?

Yes.

I know that you recently started using Filshie in labor and delivery. What has been your experience using the system in that manner?

Fine. It’s quick, it’s smooth, and the feedback I get from residents at the time of surgery is, “Oh, that’s pretty neat!” Your local sales rep was at Magee last week and he was up on labor and delivery talking with me and two other surgeons who have been doing private practice, one less than two years and the other longer than me, and their responses to the Filshie were: “Oh, that’s pretty neat! We like that!”

From your perspective Dr. Kellerman, especially being in a hospital with a teaching program and with all your experience using different methods of tubal ligation—whether it be laparoscopically or at the time of C-section, should devices like the Filshie Clip be made available for a residency program?

Well, I think that’s good practice for any technique. Let the resident decide what methods best suit their individual practice once they’re working privately, but certainly expose them to different methods beforehand. I like the Filshie system better, hands-down, and that’s all I use now, if the residents are exposed to it early on, I think a lot of them would adopt it.

Are there potential complications or potential operative challenges that, whether it is patient anatomy or another factor, pose a challenge to a certain type of sterilization methods as compared to the Filshie Clip?

Well, if the tube is really thick, there is some concern that you might tear it during a ligation. Also, there’s always the question of adhesions because you have to bring out the bigger segment compared to the Filshie. I can think of one or two C-Sections over the years where a tubal was difficult to do, no matter what system you used. That’s always an issue, so you try to select appropriate patients. The biggest concern with interval sterilization, I guess, would be if the patient is morbidly obese and there’s difficulty operating the laparoscope. Also, if the patient has had peritonitis, ruptured appendix, or endometriosis, there could be a few laparoscopic challenges that are presented. For example, one patient in her thirties had previous Myocardial Infarctions. She was a surgical risk, so we had to perform an Essure procedure on her.

Are there any patient body types or anatomies that can prove a challenge for the Essure procedure?

Maybe if the patient has a lot of intracavitary fibroids, if the surgeon is aware of them beforehand and certainly if they’ve had an ablation. You can counsel them that they can get pregnant because ablations are not a means of birth control, so that could be a contraindication.

What Filshie applicator do you normally use in the laparoscopic setting? Do you use a dual incision type?

Yes, I use the dual incision applicator and use two port sites. One subumbilically for the camera port and the other is supra-pubic for the applicator.

To my understanding, you also use a mini-lap now for postpartum. Do you encounter more tubals at the time of C-Section or post-vaginal delivery tubals?

I probably do more post C-Section sterilizations. I think most women prefer to have the procedures back-to-back. And the mini-laparoscopy incision for the postpartum, most patients tolerate that just fine, but I’d say I do more C-section tubals than post vaginal delivery tubals.

What are the key features of the Filshie Tubal Ligation System that are most beneficial to you as a surgeon?

Ease of use, reliability, and how quickly the procedure can be done. Also, the safety; those are the four big things.

Is there anything specific to postpartum?

Yes. I was curious about how it may be different with thicker tubes, but the ones I’ve done using Filshie, I haven’t had any problems.
From using the Filshie Clip in your practice, what are the key benefits that you see from a patient perspective as compared to other methods?

Well, compared to Essure®, which can be an in-office procedure, it doesn’t matter if the tube spasms or is occluded. Not that it should be a consideration, but Filshie destroys the least amount of tubal tissue compared to any others. Although, the Falope rings and electrocautery are safe, the Filshie Clip is theoretically considered safer. Also, the patient doesn’t have to use back-up contraception with the Filshie.

When you talk about safety, what potential complications do you find with electrocautery that could cause damage?

Arcing, or touching something you don’t want to can cause damage. But, if you do the surgery correctly, I suppose, it shouldn’t happen. There’s also a higher reanastomosis rate, where the tube re-forms or a fistula is created, with the electrocautery method as compared to the Filshie Clip.

Overall, what has been your experience with Filshie as you’ve been using it almost 20 years now?

Very favorable. As I said, I’ve had some problems using the Falope Ring, and there are issues with the cautery method, from success rate to possible dangers. If you’re able to perform a laparoscopy, once you’ve done that, you have done the hardest part. After that, it takes five to ten minutes once you’ve gotten the ports in and then you’re done.

From a teaching perspective, what do you feel are the best features of the Filshie Clip?

Well, the same reasons why I like it, I guess. I think it’s a safe procedure, it can be done in a fairly short period, and it saves UPMC money, as you pointed out to me on the cost. So, I would say ease of use and effectiveness.

Do the residents get the opportunity to actually use the product in the procedure?

When I use the Filshie Clip on my patients and the resident wants to scrub in, they are more than welcome. I’ll do one side, they’ll do the other, or I’ll let them do both.

What are two or three key points about the Filshie Tubal Ligation System that you would recommend to one of your peers?

The same key points as last time: that it’s easy to use, it’s effective, it’s a little bit safer because of my previous experience with the Falope ring, and it’s quick. I’ve done a procedure where I was able to get in quickly and finish in less than 15 minutes.

Would you say from your perspective most doctors are aware of the CREST Study and of the results of the various methods?

I don’t think most gynecologists were aware of the CREST Study when it first came out. So to some it might have been a little surprising that the Hulka Clip was as bad as it was. Also, electrocautery was not as good as it was thought to be. I think a reasonable, general practitioner would be aware of that in the course of their training nowadays.

In conclusion, can you please highlight once again the key points that attract you to the Filshie Tubal Ligation System?

Sure, it’s ease of use, safety and reliability. Those are the most important ones.