Correspondence

Introduction of "new" drugs

To the editor: The letter from Dr. A.B. Morrison (*Can Med Assoc J* 112: 1285, 1975) defending the activities of the health protection branch in keeping valuable drugs off the market should be reviewed after one has read the article in *Time* magazine of Sept. 29. Dr. Morrison chose to compare Canada with the United States but avoided comparing Canada with, for instance, Britain.

To regular readers of the *British Medical Journal* and *Drug and Therapeutics Bulletin* there can be no doubt that many new valuable drugs are a long time in coming to Canada. Propranolol, trimethoprim, carbenoxolone and beclomethasone are unique, valuable drugs that were kept off the Canadian market for years after they first became available. Other drugs could be cited.

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Congenital absence of vas deferens

To the editor: I was interested in Dr. K. Gopinatha Rao's recent letter to the editor (*Can Med Assoc J* 113: 185, 1975) in which he reported finding unilateral congenital absence of the vas deferens in 1 man of a series of more than 400 undergoing vasectomy.

I have only started doing vasectomies routinely in the last few years, and in my own small series of about 80 patients so far, I have already encountered 1 man with congenital unilateral absence of the vas deferens. This patient, in fact, was about the 29th or 30th in the series.

The patient was 31 years old and had requested a vasectomy. Examination of the external genitalia revealed normal testicles. The vas deferens on the right side was easily palpable, but that on the left was not palpable; because of this, the procedure was performed under general anesthesia. A right vasectomy was done through a small midline incision in the scrotum. Search for the left vas through the incision was unsuccessful. The left spermatic cord was then explored through an inguinal incision and no vas deferens was found. Postoperative semen analysis after about 2 months revealed no sperm cells, thus confirming congenital absence of the left vas deferens.

With the accumulated experience in vasectomies, I have now come to the conclusion that preliminary preoperative examination of the scrotal contents is not necessary. Examination can be carried out at the time of the vasectomy, which is routinely done under local anesthesia through a small midline scrotal incision. By palpating the spermatic cord the surgeon knows whether the vas deferens is there or not. If the vas is felt on one side and not the other, I recommend that vasectomy be carried out on the side where it is palpable, under local anesthesia. If the usual postvasectomy analysis of semen reveals no sperm cells, congenital unilateral absence of the vas deferens is verified. If, however, sperm cells are detected, exploration of the other spermatic cord through an inguinal incision under general anesthesia is indicated.

I believe this proposed scheme has certain advantages: it saves the time of a "preliminary" examination; it avoids the not too uncommon embarrassment and discomfort of the preliminary examination; and it avoids unnecessary general anesthesia and inguinal exploration when congenital absence is the reason for one vas deferens not being palpable in the scrotum.

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To the editor: I am surprised at Dr. Ho's suggestion that a preliminary examination of the scrotal contents is not necessary. I cannot understand how any doctor would undertake any operation, however trivial, without examining the area of operation. It hardly takes 1 minute to feel for the vas deferentia, and surely when the physician is spending 15 or 20 minutes interviewing the couple about a vasectomy, 1 minute spent examining the scrotal contents is not time wasted. Dr. Ho feels he could avoid the "not too uncommon embarrassment" of the preliminary examination: surely a man requesting a vasectomy expects the physician to examine the area of operation and will not be embarrassed by such an examination.

The idea of the preliminary local examination is not to look for congenital unilateral absence of the vas deferens, which is rare, but to decide whether the operation should be done under general or local anesthesia. My policy has been to do the operation under general anesthesia if one or both vas deferentia cannot easily be distinguished from the other structures of the spermatic cord, or if there is any other scrotal disorder. Often the vas deferens is plastered to the other structures of the cord because of previous inflammation, trauma or operation (herniorrhaphy). In such cases, performing the operation under general anesthesia will save the patient a lot of pain and a lot of time, and will avoid embarrassment for the surgeon. If inguinal exploration is needed it can be done easily and quickly.

There are two other disadvantages

Contributions to the Correspondence section are welcomed and if considered suitable will be published as space permits. They should be typewritten *double spaced* and should not exceed 1½ pages in length.