



## Post operative instructions for Hysteroscopic Tubal Sterilization (Essure)

### **Activity**

You may resume most normal activity as you feel up to it. Since we place an instrument inside the uterus (womb) through the vagina during this operation, You may note some vaginal discharge and spotting for several days. You should avoid intercourse, douching or tampons until this has stopped completely.

**Remember that you are NOT protected against pregnancy until the follow-up test, a hysterosalpingogram (HSG), is performed three months from now. You MUST use another form of birth control until that time.**

### **Pain relief**

Pain from this procedure generally resembles menstrual cramping. For this, we recommend using over-the-counter pain relievers such as ibuprofen (Advil), naproxen (Aleve), and acetaminophen (Tylenol). If your pain requires more relief, please call us.

### **Things to watch and call for:**

If your bleeding becomes heavier, you pass large clots, or the bleeding lasts more than 2 days.

If you develop a foul smelling vaginal discharge.

If you develop a fever greater than 100.0 degrees.

If your abdominal pain starts getting worse.

If you develop nausea or vomiting, or if you have trouble having a bowel movement.

Please call if you have any concerns or questions not covered here.

Your two week follow-- up visit is written below. At that appointment, we will schedule your 3 month hysterosalpingogram (HSG). Again, you must continue your birth control until after the HSG confirms that your tubes are blocked. You have been given a wallet card today stating that you had the Essure coils placed in your tubes. Please present this card if you ever have an MRI, CT scan, or if you ever need a surgery involving your uterus (such as a D&C or hysteroscopy).

**Return or a post-operative visit in \_\_\_\_\_**

Call the office for this appointment.

Phone numbers: Bel Air office: 443-643-4300, Havre de Grace Office: 410-939-3121

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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