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Postvasectomy Semen Analysis

To the Editor: As a family physician performing vasectomies, I read the article "Postvasectomy Semen Analysis: Why Patients Don't Follow-Up" by Dr. Smucker and his colleagues[1] with great interest. I was very surprised to read that one of the methods of semen sample collection was withdrawal. I don't consider withdrawal to be an effective form of contraception and would not want to recommend it to a patient while trying to establish aspermia. This would be especially unsafe for the occasional patient with an anomalous vas.

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The above letter was referred to the author of the article in question, who offers the following reply:

To the Editor: I appreciate Dr. Stulberg's thoughtful comment, which refers to an important detail when counseling patients regarding postvasectomy semen analysis.

While physicians in our group often mentioned withdrawal as a method for collecting a semen specimen, it was never recommended as an effective form of contraception during the initial weeks following vasectomy. Indeed, the most important task for the physician in giving postoperative instruction is to make certain that the couple will be using an effective method of temporary contraception until aspermia can be established. Most patients will choose to use oral contraceptives, a diaphragm, or condoms with or without spermicidal agents.

When a diaphragm or oral contraceptives are used for contraception, withdrawal during intercourse can safely be used as a method of semen specimen collection. If the couple is already using condoms for contraception, it is easiest to instruct them to use simply a plain condom to collect the specimen.

We encourage patients to use either masturbation or a plain condom as the best methods to collect a postvasectomy semen specimen. For the occasional patient who feels uncomfortable with these two methods, early withdrawal during intercourse is a reasonable alternative *if* another effective form of contraception is being used by the couple.

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Smoking Cessation and Stress

To the Editor: I am writing in response to Dr. Morris's letter regarding "Epidemiological Abuse" that appeared in the January-February 1991 issue of the *Journal*.[1] While I agree with his basic premise, I would like to take issue with the specific example he used regarding counseling patients not to discontinue smoking during periods of increased stress. For too long Dr. Morris's assumption has been perpetrated by the medical community with no medical or scientific data to back up this assumption. In fact, I would submit that the opposite is true. In support of this, I refer to articles on a smoke-free psychiatric unit, published in *Hospital and Community Psychiatry*,[2,3] and *Journal of Psychosocial Nursing*.[4] These articles concern a closed psychiatric unit that developed a no-smoking policy. The study found no increase in use of sedatives after the smoking ban compared with before the smoking ban. Many of the problems the medical community has assumed to be associated with smoking cessation have little factual basis. Until the medical community recognizes nicotine use for the addiction that it is and treats it as such, we will make little progress in reducing the morbidity and mortality from this disease. Following Dr. Morris's reasoning, we should also counsel our alcoholics, cocaine addicts, and narcotics addicts not to discontinue using their particular substance of choice during times of personal crises.

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