Fallopian tube removal

A counseling guide for planned abdominal or pelvic surgery

Start with permission

"Would you like to discuss an optional step during your planned surgery that may lower your future risk of ovarian cancer?"

A brief opener

"Many ovarian cancers start in the Fallopian tubes. If we can reach them safely during your operation, we could remove both tubes and leave your ovaries in place. This may lower your future cancer risk, but it does not remove all risk.

Removing both tubes is permanent and prevents natural pregnancy. Your ovaries would remain, so immediate menopause is not expected. The long-term effect on menopause timing is still being studied.

Removing the tubes adds operating time and may add risks. We would leave them in place if removal were unsafe. You can choose your planned surgery without this extra step. What questions or concerns would you like to discuss?"

Use this to open a conversation. Complete individualized counseling and consent; a short script does not replace them.

Before the patient decides

Understand the patient's priorities

Ask about future pregnancy plans, keeping organs, cancer concerns, and fear of regret. If unsure, pause the decision and offer further discussion.

Check inherited risk

Review genetic results and personal/family cancer history. A known pathogenic variant or concerning history warrants genetics or gynecologic oncology input. Tube removal alone is not an established substitute for the prevention plan used in high-risk patients. [8]

Personalize the operation

Explain added time and the patient's bleeding, infection, and organ-injury risks. Discuss possible noncompletion, recovery, pathology follow-up, and costs. Do not promise no added risk or a fixed number of minutes.

Support an unpressured choice

Offer the planned operation alone as a valid option. Invite questions, provide an interpreter when needed, and respect a decision to decline. Do not infer consent from age or completed childbearing.

Ask the patient to explain it back

"In your own words, what would be removed, what would stay, and what would this mean for future pregnancy?" Then ask what matters most and what questions remain.

MI-MAGIC's initial Michigan implementation focuses on appendectomy and colorectal surgery in patients age 50 and older. Age alone does not establish eligibility or consent. Clinical privileges and any proctoring requirements are determined by the hospital.

Answering common questions

"How much protection would I get?"
Explain that studies associate removal with fewer ovarian cancers, but benefit varies. An Ontario cohort found an adjusted hazard ratio of 0.60 (95% CI 0.36-0.98) versus hysterectomy alone or tubal ligation. This is observational evidence, not a guaranteed lifetime effect. [2]

"Will it affect my hormones?"
The ovaries remain. A large cohort found no increase in menopause-related visits or hormone-therapy initiation; these were indirect measures. A small randomized substudy did not establish noninferiority for anti-Müllerian hormone (AMH) at one year. This does not prove harm; long-term menopause timing remains uncertain. [3,4]

"Could I still become pregnant?"
Both tubes are permanently removed. Tubal reversal is not possible. IVF may be an option for some patients, depending on ovarian function and other factors, but availability and success are not assured. Discuss fertility goals before consent. [6]

"Is it safe during my operation?"
A randomized sterilization trial found noninferior short-term complications within its prespecified margin. That result does not establish safety for every abdominal operation. Discuss the planned procedure and individual anatomy; avoid removal when access or dissection is unsafe. [1,5]

"Do I need to do this?"
The additional procedure is optional. Patients may decline or withdraw consent before surgery. If a patient wants more discussion, arrange it; do not turn an unfinished conversation into an automatic yes.

"Will insurance cover it?"
Ask the local billing and consent team early. If Medicaid sterilization rules apply, federal requirements generally include consent 30-180 days before the procedure, with limited exceptions. Confirm applicability and required forms locally; do not promise coverage. [7]

Document the conversation and arrange follow-up

Record the patient's preference, reproductive plans, benefits and uncertainty, individualized risks, alternatives, and consent. Agree what happens if removal is unsafe. After surgery, explain what was done and how pathology results will be communicated. Give the patient the handout and mi-magic.com/patient.

SELECTED EVIDENCE AND GUIDANCE

1. ACOG, 2026. Obstet Gynecol. DOI: 10.1097/AOG.0000000000006400
2. Bahrami, 2026. J Natl Cancer Inst. DOI: 10.1093/jnci/djag251
3. Hanley, 2020. Am J Obstet Gynecol. DOI: 10.1016/j.ajog.2020.02.005
4. Darelius, 2026. Acta Obstet Gynecol Scand. DOI: 10.1111/aogs.70247
5. Strandell, 2024. Lancet Reg Health Eur. DOI: 10.1016/j.lanepe.2024.101026
6. ACOG, 2019. Obstet Gynecol. DOI: 10.1097/AOG.0000000000003164
7. 42 CFR Part 441, Subpart F. Sterilization consent and payment requirements.
8. National Cancer Institute. BRCA Gene Changes: Cancer Risk and Genetic Testing.

Educational support for shared decision-making. Apply current guidance, clinical judgment, and local hospital requirements. Prepared September 2026.