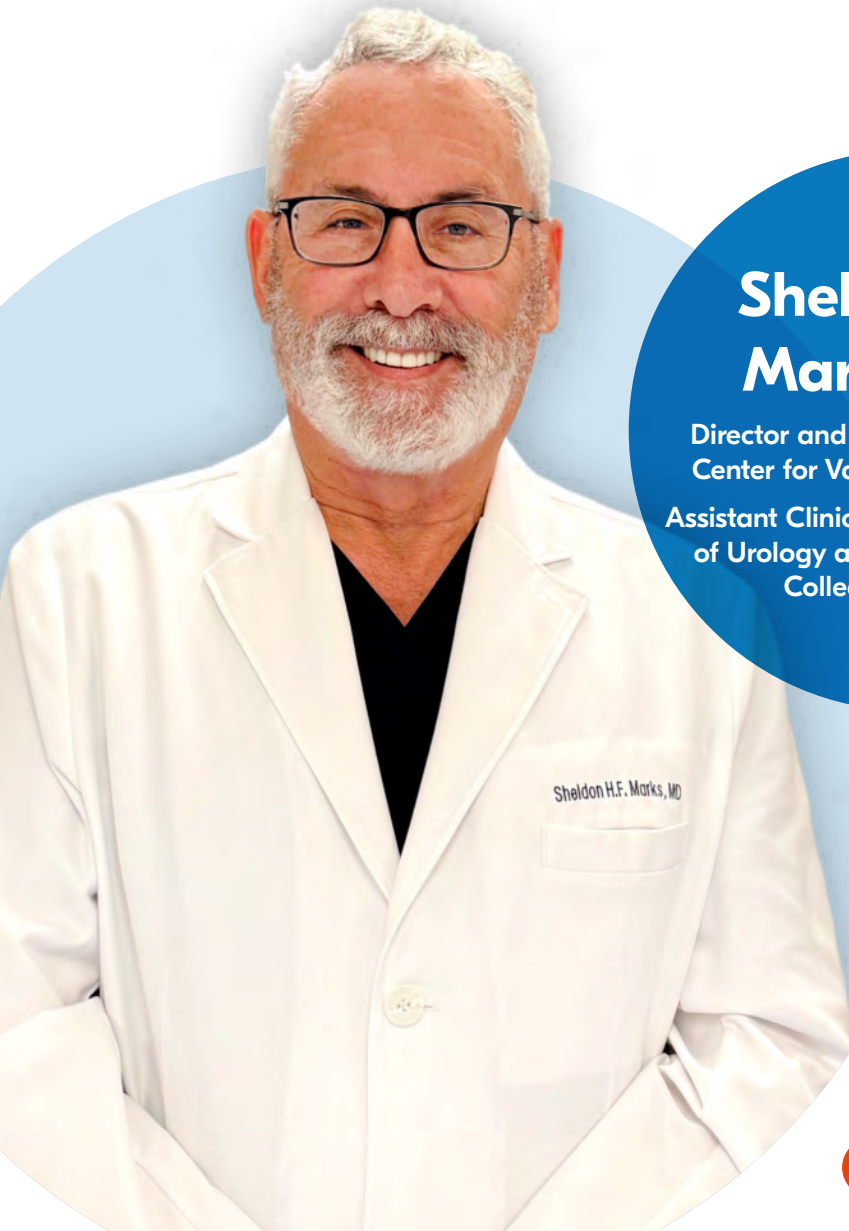


CLINICAL CASE STUDY

Microsurgical Vasovasostomy & Vasoepididymostomy.

Sharpint M.E.T. Bi-Curve Microsutures
Mastering Microvascular Anastomosis.



Sheldon H.F. Marks, M.D.

Director and Founder, International
Center for Vasectomy Reversal, P.C.

Assistant Clinical Professor Department
of Urology at University of Arizona
College of Medicine.

Vasectomy Reversal – Key Facts



500,000+

Vasectomy performed each year in the US¹.



1 in 20

Men seek fertility restoration².



Preferred technique

Microsurgical vasectomy reversal offers the highest success and is cost-effective^{3,4}.



High skillset

Among the most technically demanding procedures in microsurgery⁵.



M.E.T. Bi-Curve

Mastering microvascular anastomosis for greater precision and better outcomes.



270+

Microsurgical vasectomy reversals performed annually
International Center for Vasectomy Reversal Tucson,
Arizona, USA.

Patient History

A healthy 43-year-old male, BMI 28, presented seeking restoration of fertility. He had fathered two children in a previous marriage and underwent vasectomy twelve years ago, complicated post-operatively by a large left hematoma that resolved without surgical drainage. He is now in a new relationship with a 34-year-old female who has had no prior pregnancies. Together they wish to conceive naturally.

Examination

Right, medium sperm granuloma at the vasectomy site, mid scrotum, nontender. Metal clips palpable. Epididymis flat, without induration or cysts.

Left, small 2 cm vasal gap low in the spermatic cord, just above the testicle, with dense peri-vasal firmness. Metal clips palpable. Head and body of epididymis full and firm, no cysts. Testicles normal size and consistency, without masses or induration.

Surgical Procedure

Elective outpatient surgery.

Mild IV sedation with local - 1% lidocaine and 0.5% bupivacaine.

Vertical 3cm midline incision.

Right granuloma delivered and excised, vasal fluid + for whole, motile sperm.

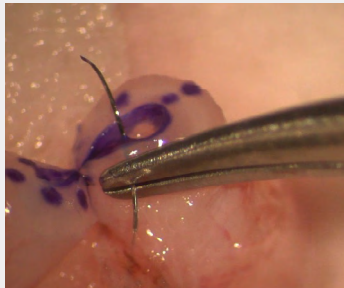
Right microsurgical 4-layer vasovasostomy:

- Mucosal layer: 6 interrupted 10-0 nylon double sutures with M.E.T. Bi-Curve 100 micron needle.
- Muscularis: 10 interrupted 9-0 nylon sutures with M.E.T. 140 micron $\frac{3}{8}$ needle.
- Adventitial: 2 layers, 8 interrupted 7-0 nylon sutures, each layer.
- Left vasal defect delivered, excised with no sperm or parts seen in vasal fluid.
- Left testicle delivered, tunica vaginalis opened. Head of epididymis with plump, full tubules; induration palpated mid body consistent with epididymal blow-out.
- Tubule teased out, top inked and opened, confirming motile sperm.

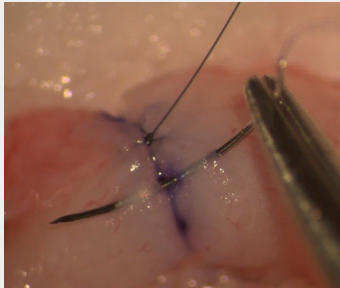
Left microsurgical 3 layer intussusception vasoepididymostomy:

- 3 interrupted 9-0 nylon sutures with M.E.T. 140 micron $\frac{3}{8}$ needle to reinforce posterior vasal muscularis to posterior epididymal tunica.
- 2 sutures parallel alongside longitudinal epididymal defect with 10-0 nylon sutures with double-armed M.E.T. Bi-Curve 70 micron needle.
- Posterior then anterior 10-0 needles passed into vasal lumen and brought out muscularis, tied.
- 3 interrupted 9-0 nylon sutures with M.E.T. 140 micron $\frac{3}{8}$ needle to reinforce anterior vasal muscularis to anterior epididymal tunica.
- 7-0 interrupted for securing adventitia of vas to tunica to reduce tension over VE anastomosis.
- Tunica vaginalis closed with running 4-0 Polysyn.
- Closure hemi-scrotal compartments interrupted 4-0 Polysyn.
- 5-0 Monoderm running subcuticular skin closure.

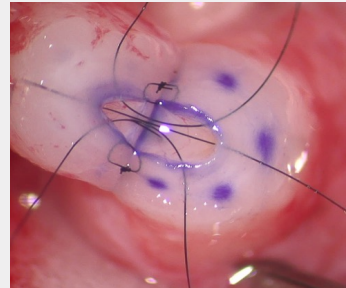
Vasovasostomy (VV)



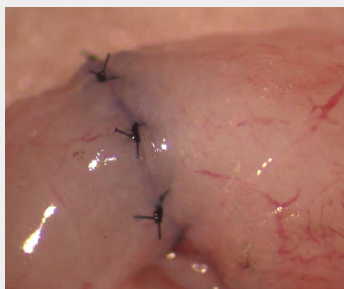
Inner layer: passage of the **M.E.T. Bi-Curve needle** in through the muscularis and out just inside the vasal lumen.



2nd layer: passage of an interrupted vasal muscularis **9-0 M.E.T. Bi-Curve needle**.

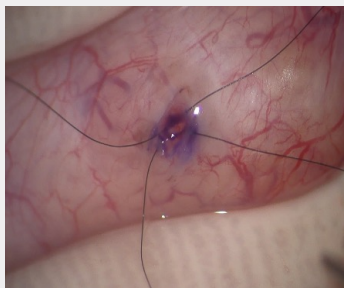


Posterior mucosal layer **10-0 sutures** tied, anterior mucosal layer **10-0 sutures** placed.

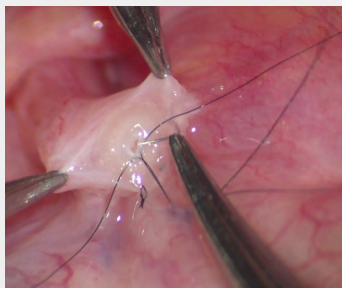


2nd layer: completed interrupted vasal muscularis **9-0 sutures**.

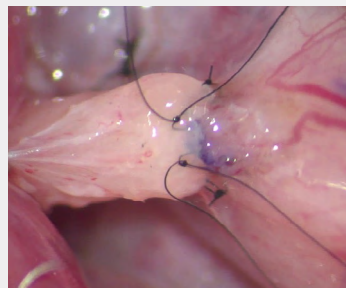
Vasoepididymostomy (VE)



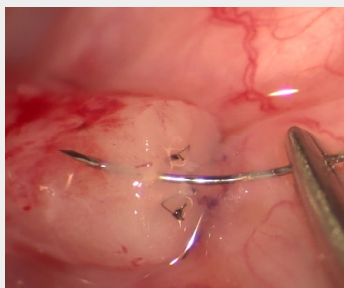
Placement of the **10-0 sutures** with **M.E.T. Bi-Curve needles** longitudinally alongside epididymal tubule window,



Passing the **10-0 suture** on **M.E.T. Bi-Curve needle** into the vasal lumen.



Tying the **10-0 nylon** to complete the intussusception of the open epididymal tubule into the vasal lumen.



Passage of the **9-0 M.E.T. Bi-Curve needle** to secure the epididymal tunica to the vas.



Completed interrupted **9-0 nylon** of the vas to epididymal tunica.

The information contained in this case study is based on the clinical experience of the author and is intended for educational purposes only. Clinical decisions should always be based on the individual patient's condition and the treating physician's professional judgment.

CONCLUSIONS

In this case, Dr. Marks reported that **Sharp^{point} M.E.T. Bi-Curve microneedles** supported **precise microsuture placement** with **minimal collateral tissue disruption**, which he associates with **reduced inflammation and scarring**.

In Dr. Marks' experience, use of the **M.E.T. Bi-Curve needle** contributed to a **shorter operating time**.

Based on his clinical experience, Dr. Marks reports **favorable outcomes** using this technique.

AA-2492

1. 1" Suture Length
2. Dual Arm
3. Flat Pressed, Square Needle Body
4. M.E.T. Optimized Needle Tip
5. **Bi-Curve Ergonomics**

Product codes with the golden advantages: AA-2492 and AA-1824.



The **Golden 5** Advantages of M.E.T. Bi-Curve Technology

“SharpPoint M.E.T. Bi-Curve microneedles provide the precision, control and tissue preservation required for successful microsurgical vasectomy reversal.”

Sheldon H.F. Marks, M.D.
International Center for Vasectomy
Reversal, University of Arizona

Preferred Suture Selection for Microsurgical Vasectomy Reversal

MUCOSAL ANASTOMOSIS	AA-2492	10-0 Nylon	M.E.T. Bi-Curve	70 µm	1”
MUSCULARIS	AA-012I	9-0 Nylon	M.E.T. ¾ Circle	140 µm	5”
REINFORCEMENT SUTURES	OL318060	7-0 Nylon	Reverse Cutting	8 mm	12”
TENSION RELIEF & ADVENTITIA	OL318060	7-0 Nylon	Reverse Cutting	8 mm	12”
SUBCUTICULAR SKIN CLOSURE	Y493N	5-0 Monoderm	Precision Reverse Cutting	13mm	18”
TUNICA VAGINALIS CLOSURE	G422N	4-0 Polysyn	Reverse Cutting	19mm	27”
TISSUE LAYERS (1–2 layers)	G422N	4-0 Polysyn	Reverse Cutting	19mm	27”

Disclaimer: The testimonials reflect the surgeon’s personal opinion and experience, which may not represent other surgeons or the medical community. Results may vary; consult all relevant data for clinical decisions.

1. Ostrowski KA, Holt SK, Haynes B, et al. Evaluation of Vasectomy Trends in the United States. *Urology*. 2018;118:76–79. — and Eisenberg ML, Lipshultz LI. *J Urol*. 2010 (PMID 20850832). Namekawa T, et al. Vasectomy reversal: a clinical update. *Asian J Androl*. 2016;18(3):365–371 (PMID 26975488). — and Dickey RM, et al. *Transl Androl Urol*. 2015;4(2):168–178 (PMC5583052). Belker AM, Thomas AJ Jr, Fuchs EF, Konnak JW, Sharlip ID. Results of 1,469 microsurgical vasectomy reversals by the Vasovasostomy Study Group. *J Urol*. 1991;145(3):505–511 (PMID 1997700). — and Seth A, et al. *Andrology*. 2024 (doi:10.1111/andr.13543). Pavlovich CP, Schlegel PN. Fertility options after vasectomy: a cost-effectiveness analysis. *Fertil Steril*. 1997;67(1):133–141 (PMID 8986698). — corroborated by Lee R, et al. *Hum Reprod*. 2008 (confirm exact citation). For an authoritative umbrella anchor, add the AUA/ASRM guideline: Schlegel PN, Sigman M, Collura B, et al. *Diagnosis and Treatment of Infertility in Men: AUA/ASRM Guideline*. *J Urol*. 2021. 2. Namekawa T, et al. Vasectomy reversal: a clinical update. *Asian J Androl*. 2016;18(3):365–371 (PMID 26975488). — and Dickey RM, et al. *Transl Androl Urol*. 2015;4(2):168–178 (PMC5583052). 3. Belker AM, Thomas AJ Jr, Fuchs EF, Konnak JW, Sharlip ID. Results of 1,469 microsurgical vasectomy reversals by the Vasovasostomy Study Group. *J Urol*. 1991;145(3):505–511 (PMID 1997700). — and Seth A, et al. *Andrology*. 2024 (doi:10.1111/andr.13543). 4. Pavlovich CP, Schlegel PN. Fertility options after vasectomy: a cost-effectiveness analysis. *Fertil Steril*. 1997;67(1):133–141 (PMID 8986698). — corroborated by Lee R, et al. *Hum Reprod*. 2008 (confirm exact citation). 5. For an authoritative umbrella anchor, add the AUA/ASRM guideline: Schlegel PN, Sigman M, Collura B, et al. *Diagnosis and Treatment of Infertility in Men: AUA/ASRM Guideline*. *J Urol*. 2021.

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More resources, case studies, videos and information can be found on [Corza’s website](#), [YouTube](#), and [Vimeo](#) channels.  

The brochure describes the use of a surgical device and offers possible suture options. However, surgeons choose the item code(s) and surgical technique(s) depending on preference, experience, and patient needs.

For complete indications, contraindications, warnings, precautions, and adverse reactions, please refer to the complete Instructions For Use (IFU).



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