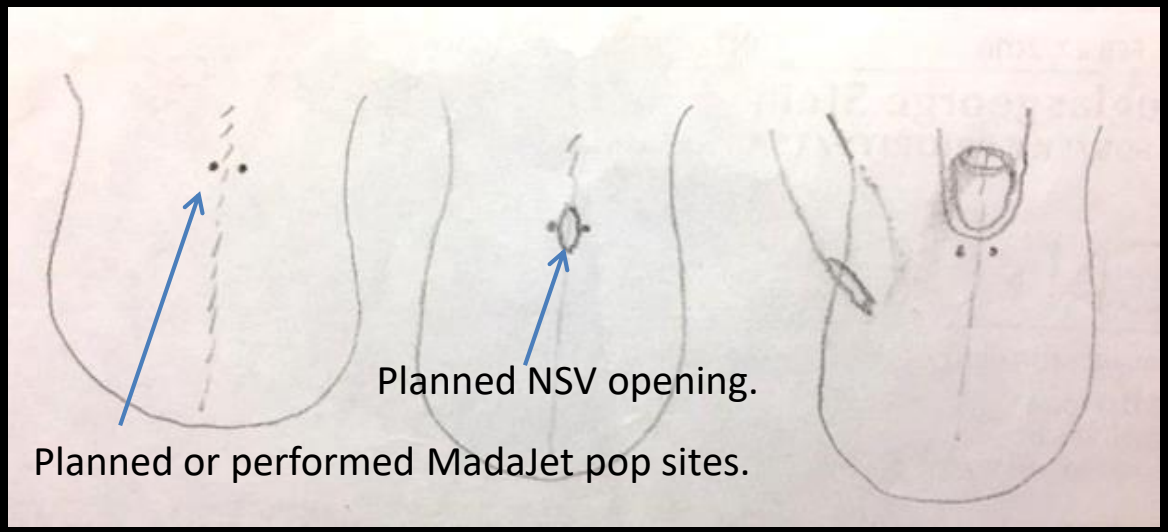
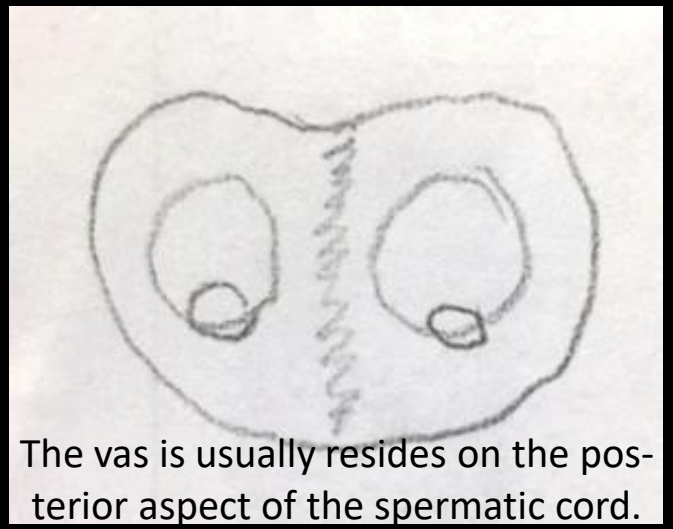
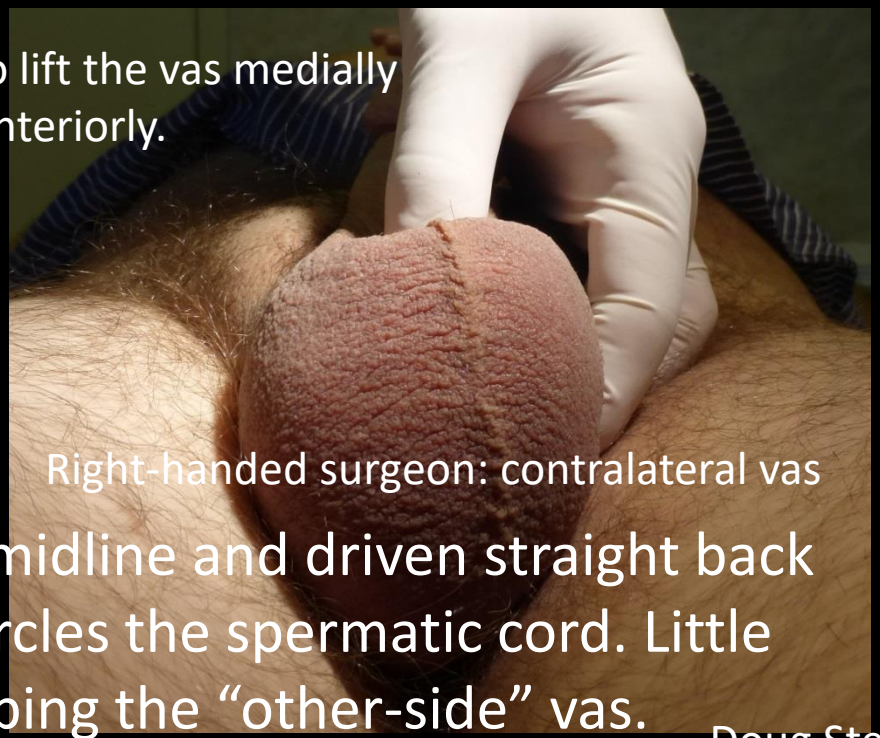
Bringing the CONTRALATERAL vas into a subcutaneous position, for no-needle anesthesia.





The objective is to lift the vas medially and anteriorly.

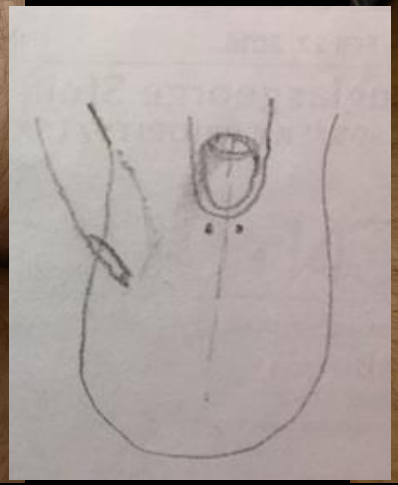


The thumb is positioned on the midline and driven straight back toward the rectum until it encircles the spermatic cord. Little chance of mistakenly grasping the “other-side” vas.

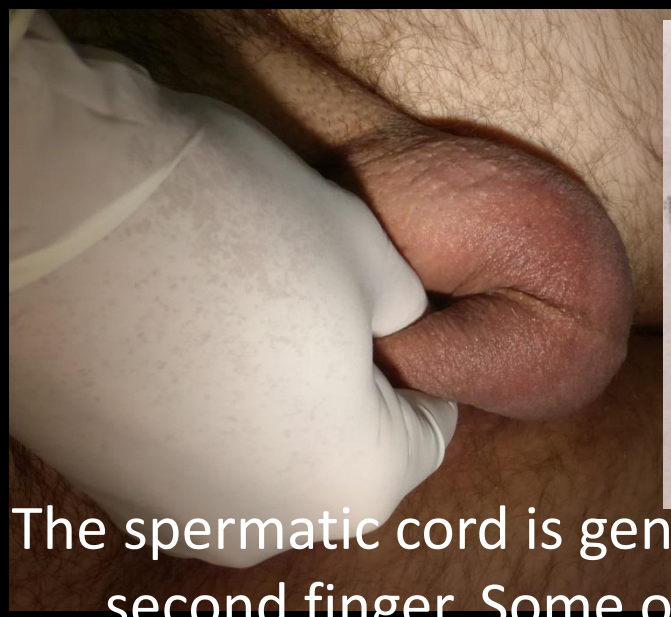
Doug Stein

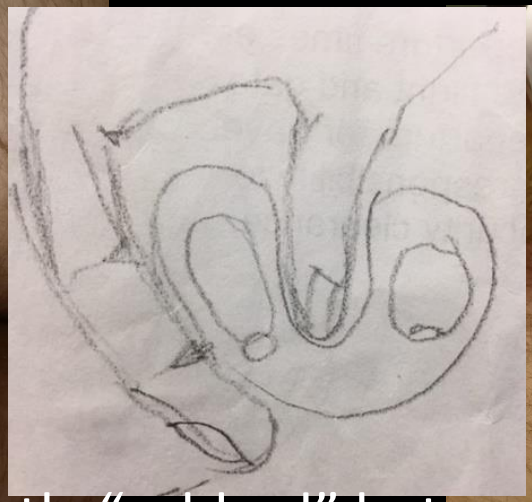
Bringing the CONTRALATERAL vas into a subcutaneous position, for no-needle anesthesia.

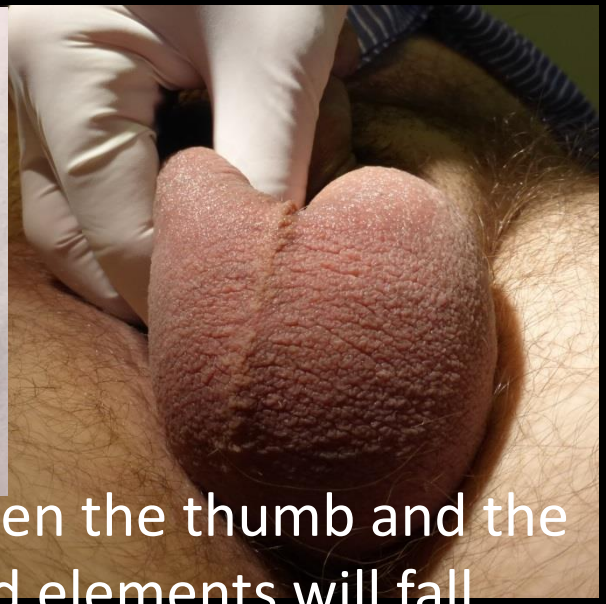
Anterior view.



Inferior view.



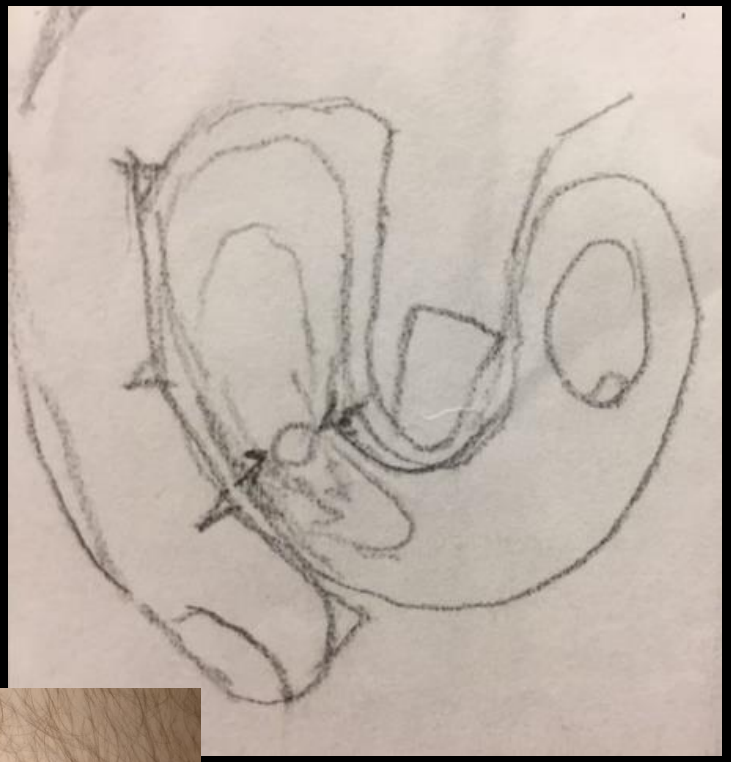




The spermatic cord is gently “rubbed” between the thumb and the second finger. Some of the spermatic cord elements will fall posterior and some will remain anterior to the vas.

Doug Stein

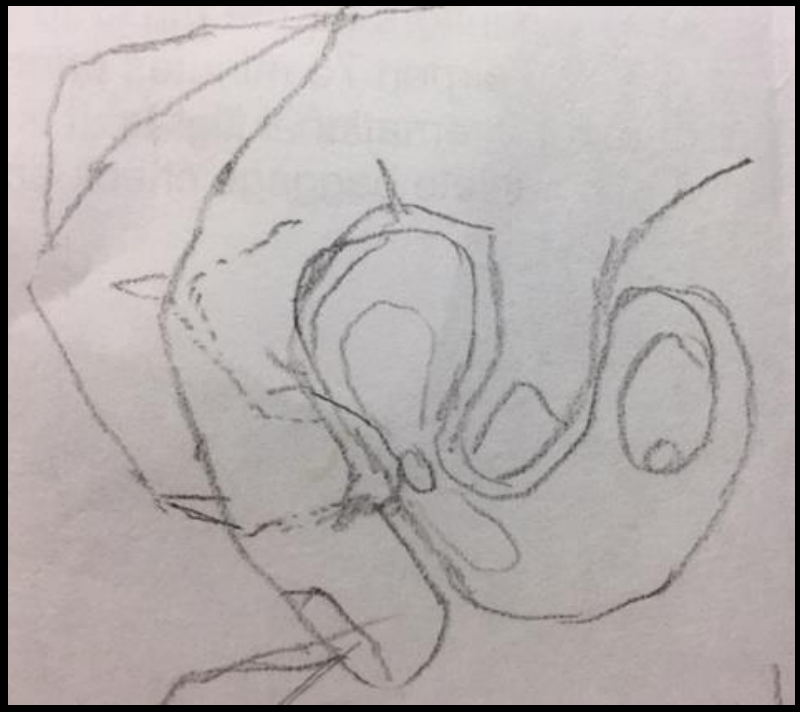
Bringing the CONTRALATERAL vas into a subcutaneous position, for no-needle anesthesia.



The vas is engaged between the thumb tip and the second-finger DIP joint.

Doug Stein

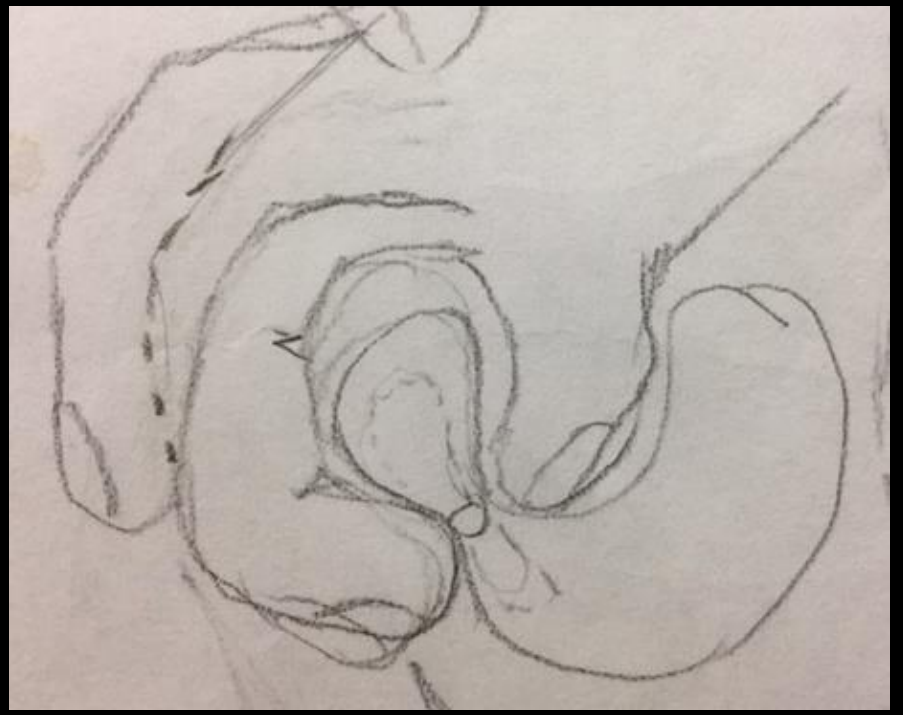
Bringing the CONTRALATERAL vas into a subcutaneous position, for no-needle anesthesia.

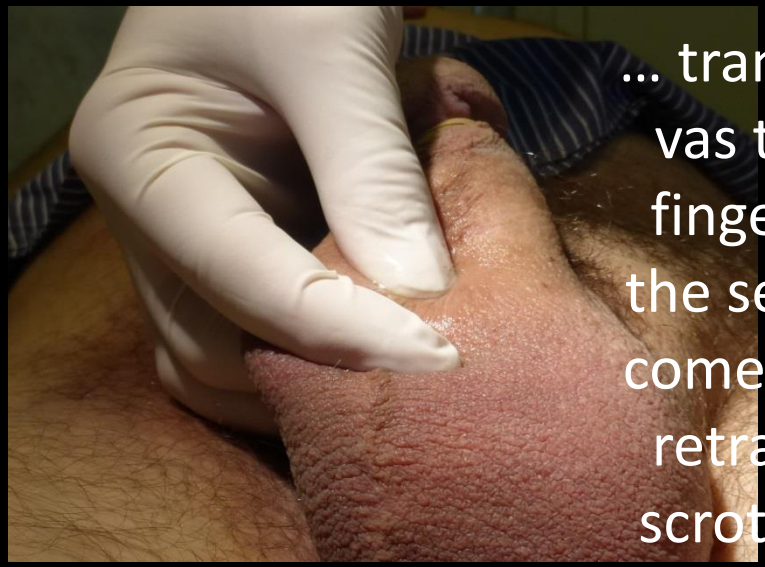


The third finger TIP is then brought onto the vas …

Doug Stein

Bringing the CONTRALATERAL vas into a subcutaneous position, for no-needle anesthesia.

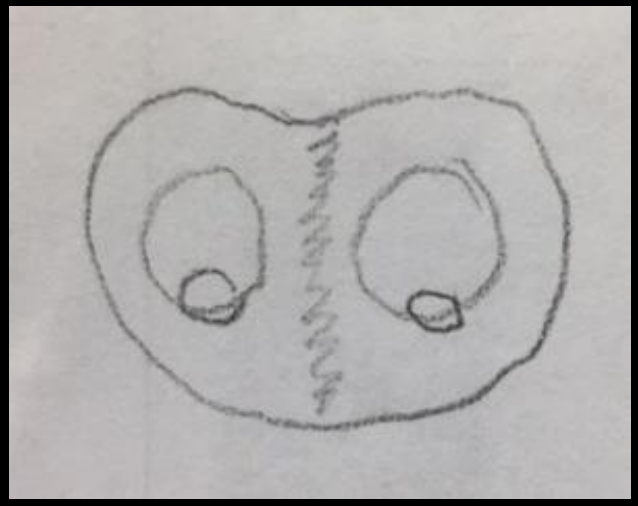


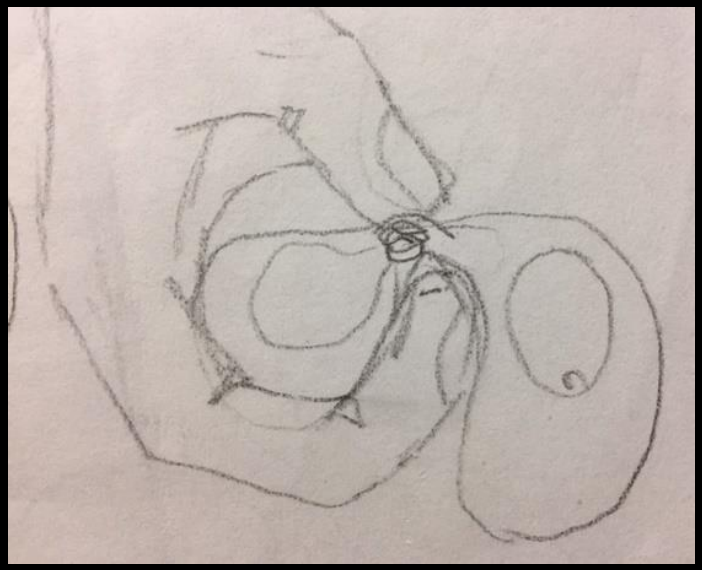


… transferring the vas to the third finger TIP while the second finger comes forward to retract anterior scrotal wall skin.

Doug Stein

Bringing the CONTRALATERAL vas into a subcutaneous position, for no-needle anesthesia.



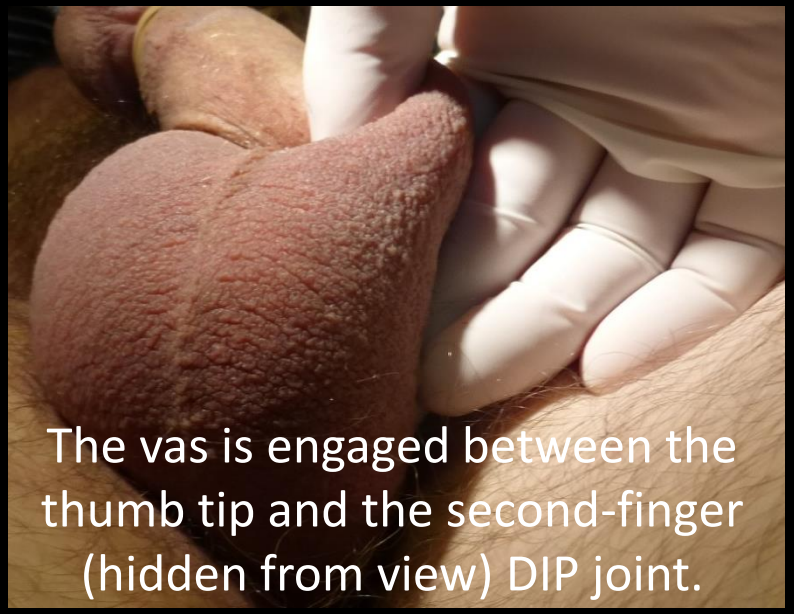


Little chance of getting the "other-side" vas by mistake.

Doug Stein

Bringing the IPSILATERAL vas into a subcutaneous position, for no-needle anesthesia.

Again the thumb is placed on the midline and driven toward the rectum, encircling the ipsilateral spermatic cord.



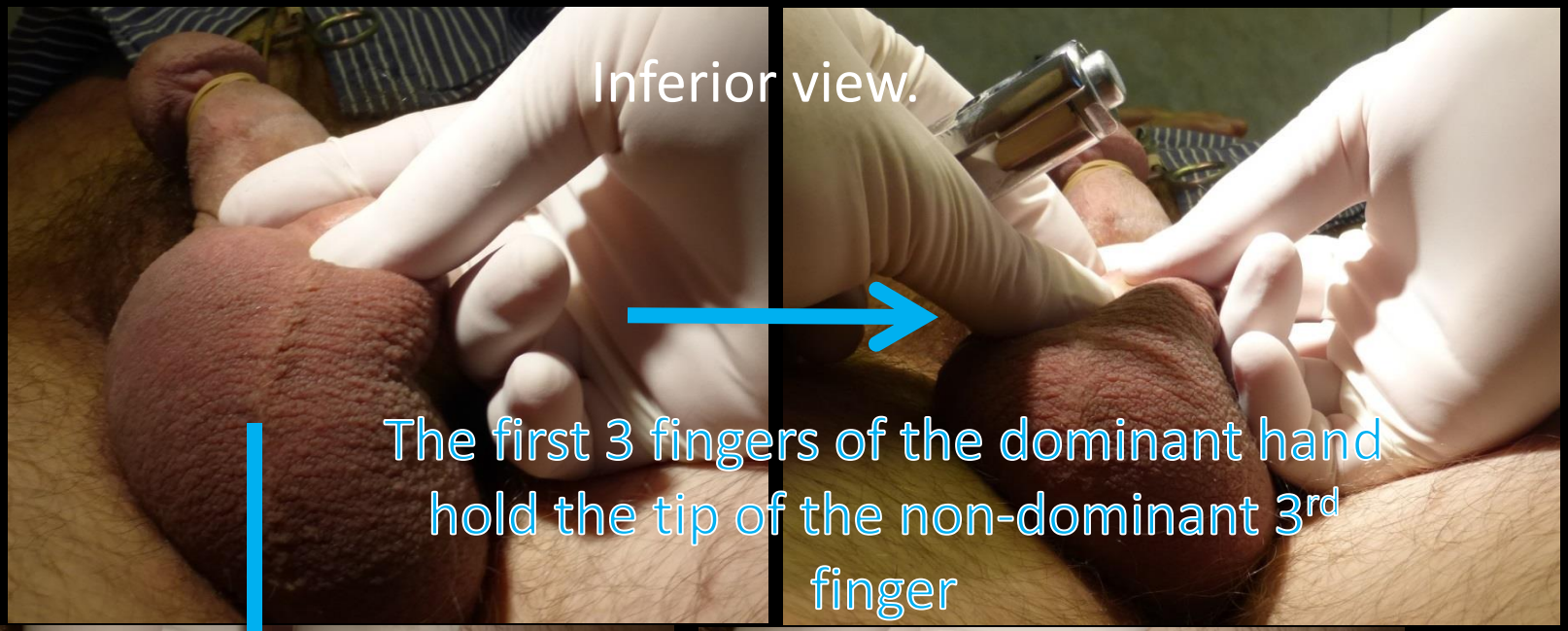
The vas is engaged between the thumb tip and the second-finger (hidden from view) DIP joint.

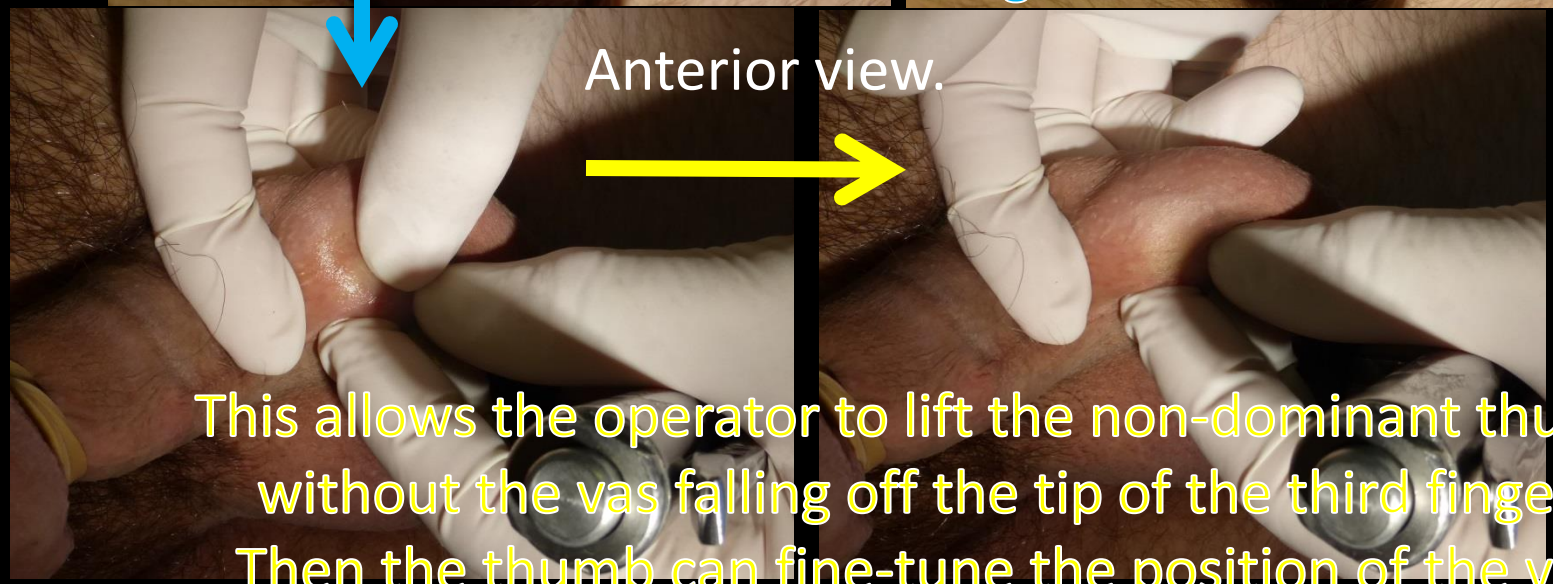
The third finger TIP is then brought onto the vas …

… and the vas is pushed medially and anteriorly toward the median raphe.

Doug Stein

Bringing the IPSILATERAL vas into a subcutaneous position, for no-needle anesthesia.





This allows the operator to lift the non-dominant thumb without the vas falling off the tip of the third finger. Then the thumb can fine-tune the position of the vas and roll the scrotal skin to get the vas into the midline.

Doug Stein

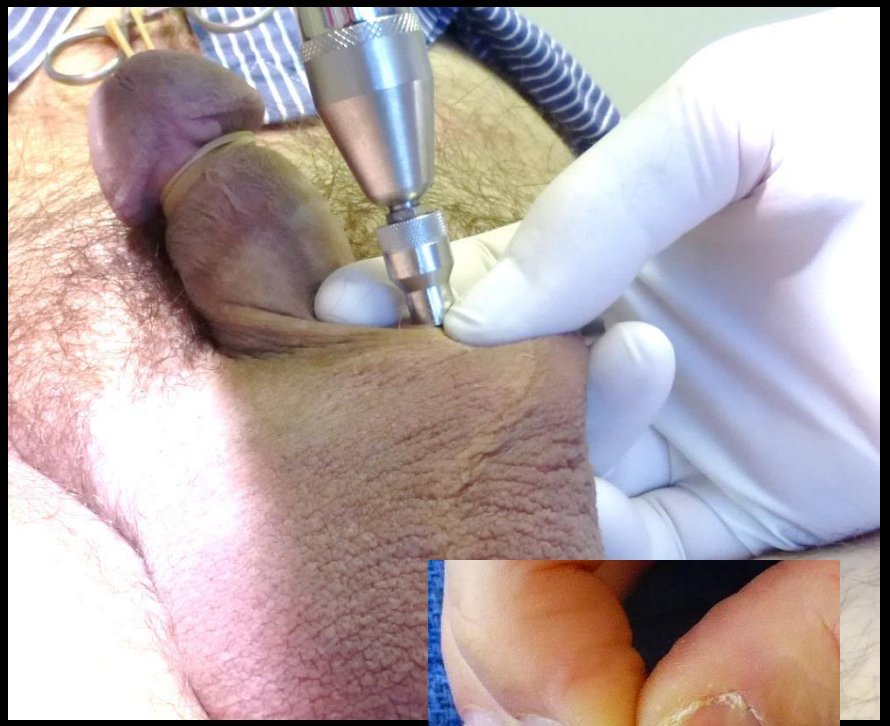
Bringing the IPSILATERAL vas into a subcutaneous position, for no-needle anesthesia.

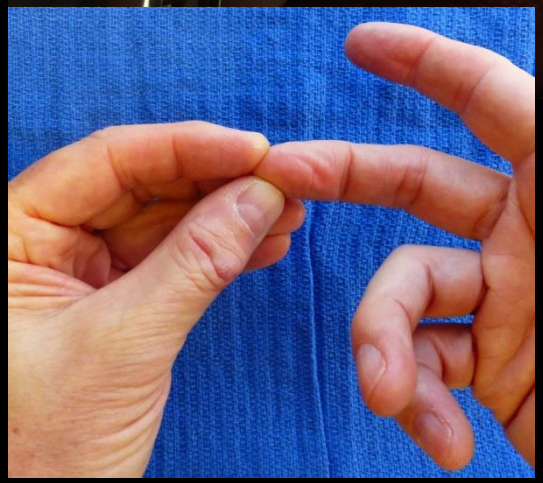
View from above:

1. As your 3rd finger tip comes forward with the vas on it, hold that fingertip with the first 3 fingertips of your dominant hand.
2. The vas cannot fall off the end of your 3rd finger because your dominant hand fingers are holding it.
3. Now fine-tune the position of the vas with your positioning thumb.
4. When the vas is in the perfect position, squeeze it ("lock on") between your thumb and 3rd finger tip.

Doug Stein

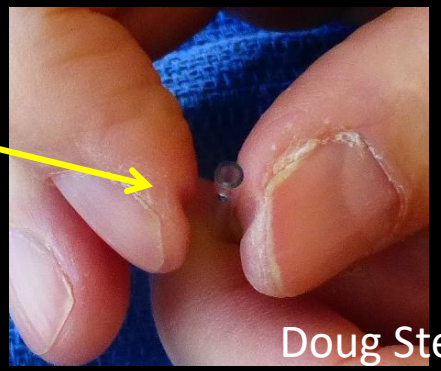
Bringing the IPSILATERAL vas into a subcutaneous position, for no-needle anesthesia.





It's easy to practice holding the 3rd finger tip.

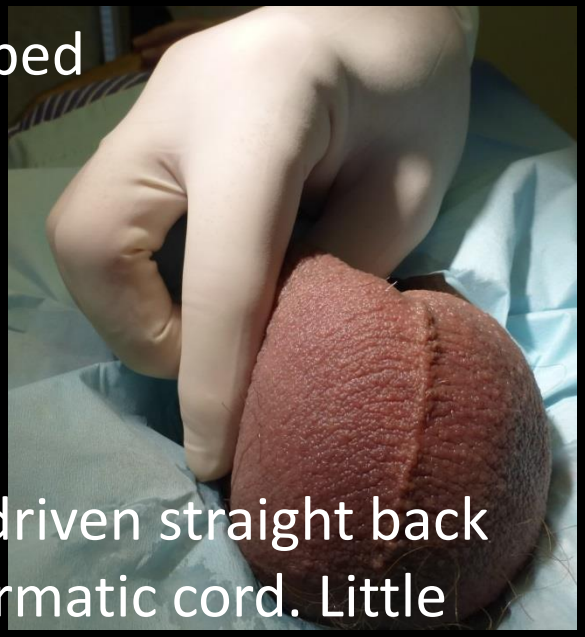
When the vas is in perfect position, "lock on" by squeezing it. It will make indentations in the pulp of your fingertips from which it cannot escape while you apply anesthesia or a ring clamp.



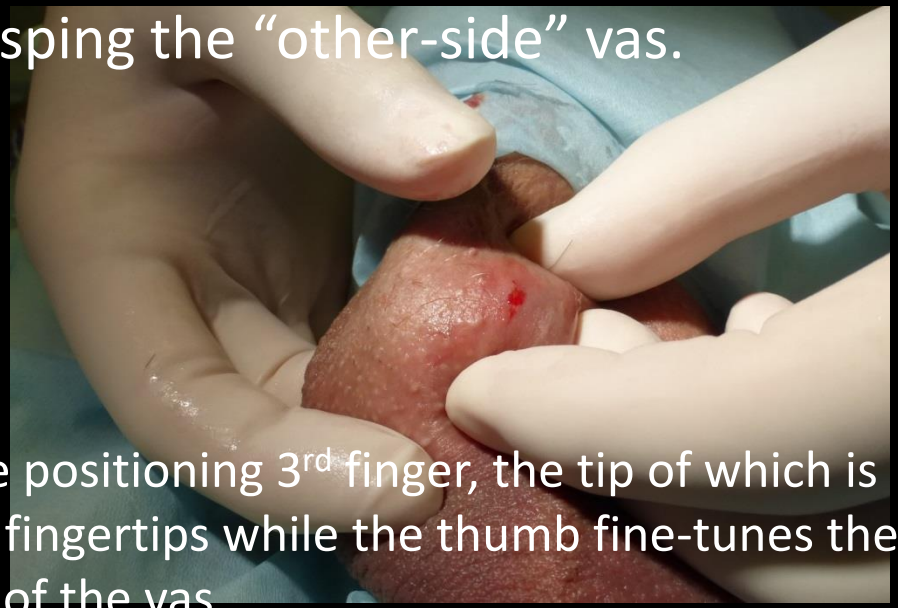
Doug Stein

Bringing the CONTRALATERAL vas into a subcutaneous position, for NSV.

Patient now prepped and draped



The thumb is positioned on the midline and driven straight back toward the rectum until it encircles the spermatic cord. Little chance of mistakenly grasping the “other-side” vas.



The vas is driven anteromedially by the positioning 3rd finger, the tip of which is grasped with the first 3 dominant-hand fingertips while the thumb fine-tunes the position of the vas.

Doug Stein

Bringing the CONTRALATERAL vas into a subcutaneous position, for NSV.

The vas is grasped with the ring clamp and it’s off to the races.

Doug Stein