INTRODUCTION

The difference in achieving a precise diagnosis of many gynaecological disorders is an intriguing problem of gynaecologist. Patients with unexplained infertility, suspected ectopic pregnancy, amenorrhoea and those with chronic pelvic pain are some of the diagnostic riddles faced by us.

Accurate diagnosis of lesions of the vulva, vagina and cervix is made by augmenting touch and vision with special procedures such as bacteriological investigations, cytological examinations, colposcopy and biopsy. The internal genitalia above the level of cervix have hitherto been inaccessible to these direct helps, and the gaps have been partially filled by diagnostic curettage, hormone investigations, tubal insufflation and hysterosalpingography. Examination under anaesthesia combined with clinical assessment remains a standard diagnostic aid in gynaecology but there is a limit to amount of information obtained; extension of the investigation to direct visualization of pelvic contents is therefore logical and desirable. Prior to advent of laparoscopy diagnostic laparotomy was the only answer in them. The value of information which can be
obtained is similar to that of exploratory laparotomy, but the method is more simple, less traumatic and readily accepted by patients.

Diagnostic laparoscopy provides a direct visual access to inner pelvic anatomy without resorting to major abdominal surgery. The physiology of the ovaries, fallopian tubes and uterus can now be studied in more detail and fresh knowledge may be revealed. In addition, limited operations such as sterilization, division of adhesions, tubal lavage, fimbrial dilatation, salpingostomy, fulguration of endometriotic deposits, aspiration of follicular cysts or endometriotic cysts, recovery of ova, ovarian biopsy, myomectomy, uterine ventral suspension and deposition of sperms in the fallopian tubes, are safely carried out with the minimum of disturbance.

Direct visualization of pelvic organs can greatly improve the accuracy of diagnosis when surgical intervention is undesirable and when observation or empirical therapy is conservative or ineffective. Laparoscopy has shown period of great enthusiasm followed by condemnation because of occurrence of some complications. But today the availability of excellent instruments, safe source of gas and superb anaesthesia, all have pointed safety factors.
In this era of rising medical costs, where economy has assumed a major role, diagnostic laparoscopy could provide the gynaecologist an economy with a shortened hospital stay.

The critical factors in evaluation of diagnostic laparoscopy is how far it can contribute to the management of the patients. Laparoscopy has precisely fulfilled the goals set up by its developers and has revolutionized the practice of gynaecology. Physicians have grasped the concept that the laparoscope provides a picture window to what could only be palpated previously or seen through a large laparotomy incision. Patients have benefited from the rapid diagnostic and recovery time, minimal cosmetic injury, greatly reduced costs, elimination of sexual restriction, avoidance of the risks of major surgery and many fewer delays in treatment. Laparoscopy has eliminated the risk and frustration of clinical observation, and has made possible immediate, definitive therapy for infertility, endometriosis, acute and chronic pelvic pain, blunt abdominal trauma, malignancies with and without metastasis and congenital abnormalities. Laparoscopy is the method of choice for removing foreign bodies, such as intrauterine devices or peritoneal dialysis catheters, from the peritoneal cavity.
Thus, laparoscopy is an elegant procedure based on simple concepts but with a complex application of those concepts.

AIMS OF STUDY:

1. To find out the cause of infertility in otherwise tested normal women.
2. To evaluate tubal morphology and patency by dye testing.
3. To find out the cause of obscure pelvic pain.
4. To avoid unnecessary laparotomy.
5. To investigate a case of amenorrhoea.