INTRODUCTION

Fallopian tube obstruction represents one of the most common causes of infertility ***(Sulak et al, 1987)***. Proximal tubal occlusion either unilateral or bilateral is present in up to 25-30% of cases with tubal diseases diagnosed by HSG ***(Honore et al, 1999).***

The conventional method used to study tubal patency such as hysterosalpingography (HSG) or the direct observation by laparoscopy and selective chromotubation, frequently does not allow differentiating between an insufficient filling of the tube, tubal spasm or true mechanical obstruction ***(Salazar & Mondragon, 1999).***

Selective salpingography and fallopian tube catheterization is a successful technique that is extremely useful in the diagnosis and treatment of proximal tubal obstruction in women with infertility problems ***(Serafini & Batzofin, 1989).*** It can be performed immediately after HSG when the fallopian tubes are not opacified ***(Atallah & Karam, 1999).***

Hysteroscopic fallopian tube catheterization-has been successful in selected cases of proximal tubal block ***(Deaton et al., 1990)***.

Tubal cannulation was performed under laparoscopic control using hysteroscopic guidance ***(Rimbach et al, 2001)***.

The Royal College of Obstetricians and Gynecologists (RCOG) have included selective salpingography and tubal catheterization in its evidence– based clinical guide line for the management of infertility in secondary care. In spite of being a cost-effective and minimally invasive treatment option for proximal tubal blockage, tubal catheterization has not yet become adopted across the UK. The procedure should become universally accepted, taught and practiced for the diagnosis and treatment of fallopian tube ***(Rawal et al, 2005).***

The Royal College of Obstetricians and Gynecologists has set a guide lines for training in hysteroscopic surgery and has specified the stratification of levels of training that can be achieved based on the complexity of the surgical procedure. Cannulation of proximal fallopian tube due to cornual obstruction was considered grade III hystroscopic procedure ***(RCOG, 1998)***.

Mandatory hystroscopic procedures as diagnostic hysteroscopy and biopsy, removal of IUDs (intrauterine device), polypectomy, and myomectomy (type 0) (according to the NVOG guidelines classified as level 1 and partly levels II). The other procedure (partly level II and level III) are considered advanced hysteroscopic procedures including hystroscopic catheterization ***(Helen et al., 2006).***

Tactile trans-cervical tubal cannulation may be another successful alternative treatment of proximal tubal occlusion ***(Lang & Dunaway, 1994).***

Proximal tubal cannulation may be considered as the management of choice for intraluminal pathology where proximal tubal pathology is present alone without distal tubal diseases ***(Dunphy, 1994).***

One quarter of patients diagnosed with bilateral proximal tubal occlusion on HSG do not have tubal obstruction. Among these with true occlusion, selective tubal catheterization leads to an overall pregnancy rate of 31.9% ***(Al- Jaroudi et al, 2005).***