INTRODUCTION

Laparoscopy has been a standard procedure for the gynecologist for many years . General surgeons have had limited experience with the procedure , but considerable enthusiasm for it has developed recently because of the increasing interest in laparoscopic cholecystectomy ***(Gadacz et al , 1990)*** .

Acceptance of laparoscopy into general surgery awaited the development , in the 1980s of the computer-chip television camera , which allowed videolaparoscopy to be performed ***(Stellato , 1992)*** .

Laparoscopic surgery has been performed successfully in many operations , such as adhesiolysis , cholecystectomy , appendectomy , splenectomy , vagotomy for trearment of chronic duodenal ulcer disease ***(Katkhouda and Mouiel , 1991) (Cuschieri , 1992)*** .

Dubois , (1992) carried out laparoscopic highly selective and truncal vagotomies . ***Mouiel and Katkhouda , (1993)*** added ballon pyloric dilatation to the laparoscopic truncal vagotomy and anterior lesser curve seromyotomy .

Laparoscopic vagotomy is indicated in patients in whom the disease is resistant to medical treatment inspite of perfect compliance to medical advice for at least 2 years ***(Mouiel and Katkhouda , 1992)*** .

Morbid obesity , prior abdominal operation , intra-abdominal adhesion and minor bleeding disorders , were considered as relative contraindicatins for laparoscopic surgery . Now they can be operated upon without hazards , depending on experience and special training of the surgeon ***(Sackier et al , 1992)*** .

AIM OF THE WORK

The aim of this work is to evaluate the feasibility , curability , complications , and long term results of different laparoscopic vagotomy procedures for chronic duodenal ulcer disease .