

Introduction

Intestinal obstruction in all age groups is one of the most important surgical problems facing surgeons. Obstruction of small and large intestine due to adhesions, hernia and malignancies accounted for (95%) of causes in developed countries (*Zadeh et al., 1995*).

Adhesions are deposits of fibrous tissue that occur within body cavities such as peritoneum, pleura or pericardium (*Thompson and Whawell, 1995*). Adhesion reformation refers to the recurrence of adhesions after adhesolysis. Denovo adhesions refers to existence of new adhesions that developed at sites that did not previously have adhesions (*Operative Laparoscopy group, 1991*).

The vast majority of post operative adhesions are harmless. However, pelvic adhesions may be the cause of bowel obstruction, pelvic pain and infertility. Adhesions are the most common single cause of intestinal obstruction (*Coletti and Bossart, 1994*). Although chronic postoperative pain is not life threatening, it has been attributed by some as a frequent and serious problem and laparoscopic adhesolysis improves or relieves pain in about 87% of cases (*Nezhat et al., 1990*).

Adhesions and bands are the most common cause of small bowel obstruction, the two main factors that cause adhesions are infection and ischaemia, the incidence of man-made causes of adhesive obstruction will be less with more careful and atraumatic techniques of primary surgery and the less often there is residual sepsis (*Brown and Dudley, 1995*).

It has been estimated that one third of intestinal obstructions and 15%-20% of female infertility are caused by adhesions (*Menzies, 1992*).

Adhesions are congenital or develop after an abdominal operation or infection, intraoperative tissue damage, tissue ischaemia and intra-abdominal presence of foreign material, blood, or bile, all have been shown to be potent causes of peritoneal adhesions (*Almadahl, 1990*).

Although the majority of adhesive obstruction episodes are simple, strangulation does occur. This possibility, combined with the difficulty in distinguishing simple from strangulating obstruction in the individual instance, makes the choice of operative treatment not easy, even if there are individual circumstances where conservatism may be more appropriate. (*Brown and Dudley, 1995*).

Prevention of postoperative adhesions formation is a major problem in infertility surgery. The techniques the surgeons practice to minimize peritoneal trauma remain the foundation of adhesion prevention, these include; magnification, good exposure, gentle handling of tissues, meticulous hemostasis, the use of delicate instruments and fine sutures, careful dissection and complete excision of pathological tissues, reperitonealization without tension and avoidance of foreign bodies (*Damario and Rock, 1995*). The role of microsurgical techniques is universally agreed upon (*Brown and Dudley, 1995*).

Non operative management should be reserved for situations where there is an absolute minimum of doubt that the obstruction is benign in nature, where the risks of doing harm by operation are high and where the patient settles quickly after nasogastric suction and intravenous therapy are begun (*Brown and Dudley, 1995*).