Introduction

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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 account for (95%) of causes in developed countries ***(Menzies & Ellis, 1990).***

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 adhesiolysis.

Denovo adhesions refers to existence of new adhesions that developed at sites that did not previously have adhesions ***(Schrock, 1991).***

The vast majority of postoperative 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 adhesiolysis improves or relieves pain in about 87% of cases ***(Nazhat 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 obstructions 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 either congenital or acquired due to intra-abdominal operations, infections, tissue damage, tissue

ischaemia, presence of intra-abdominal foreign material, blood or bile ***(almadahl and Burhol, 1990).***

Although the majority of adhesive obstruction episodes are simple, strangulation does occur. This possibility, combined with the difficulty in distinguishing simple from strangulation obstruction in the individual instance, makes the choice of operative treatment not easy ***(Brown and dudley, 1995).***

Prevention of postoperative adhesion formation is a major problem in inferitility 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 hemeostasis, 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 of postoperative adhesions should be reserved for situations where 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).***