INTRODUCTION

Laparoscopic ovarian drilling by electrocautery and lazer have been advocated as alternative treatment to exogenous gonadotropin therapy in anovulatory patients with polycystic ovary disease failing to respond to medical induction of ovulation ***(Keckstein, 1989)***. Ovulation rates in the range of 80-90% may be expected after this procedure and conception rates of 45-69% have been reported with 6-12 months of follow up ***(Daniell and Miller, 1989)***.

Alternatively, surgical treatment by ovarian wedge resection, although successful in inducing ovulatory cycles ***(Goldzieher and Green, 1962)***, has largely been abondoned because of the need for laparotomy and the potential for development of pelvic adhesions in up to 100% of cases and thus converting the infertility from one with an endocrine cause to one with a mechanical cause ***(Buttram and Vaquero, 1975)***. Hence, the application of microsurgical techniques for ovarian wedge resection may again render this treatment acceptable ***(Eddy et al., 1980)***.

Laparoscopic drilling of the ovarian capsule and stroma results in hormonal changes similar to those previously associated with ovarian wedge resection performed by laparoscopy ***(Greenblatt and Casper, 1987)***. Although menses