LETTERS TO THE EDITOR

Response to Hovav *et al.* [Diagnostic Laparoscopy in Primary and Secondary Infertility (J Assist Reprod Genet 1998;15:535–537)]

To the Editor: Dr. Yedidya Hovav and co-workers suggested in their contribution (1) that the role of diagnostic laparoscopy in some infertile patients is to be reconsidered because the yield is low. Many articles have been written on this particular subject and recommendations differ considerably. The different percentages of pathological findings can be explained simply by the selection of the patients. Some infertility centers suggest diagnostic laparoscopy earlier than others. Obviously, the yield of diagnostic laparoscopy will be lower there than at centers where laparoscopy is considered to be the “last-ditch effort.”

One has to keep in mind that diagnostic laparoscopy, possibly combined with hysteroscopy, is the only procedure which provides definite information on the status of the internal genitalia of a patient who has been trying to conceive for a certain length of time. Endometriosis, adhesions, etc., may be suspected by clinical findings, but laparoscopy is the only way of proving or disproving its existence. The value of ultrasonography, hysterosalpingography, and detection of ovulation by ovulation predicting kits, endometrial biopsy, hormonal studies, and other examinations is questioned. El-Minawi *et al.* concluded that hysterosalpingography is of no great benefits since its yield in patients with adhesions was poor and it missed other peritoneal pathology (2). Sowden *et al.* reported 16% false-positive and 13% false-negative findings of hysterosalpingography (3).

To judge the proper timing of laparoscopy, a number of factors need to be considered, besides the length of exposure to conception. The length of exposure includes the length of care provided to the patient at the infertility center and the time of unprotected sexual relations during the period of so-called nontrying.

Hysterosalpingography takes approximately the same time as diagnostic laparoscopy (exclusive of postoperative recovery prior to discharge of the patient after general anesthesia). The information provided by hysterosalpingography is limited to the patency of the fallopian tubes and, if properly performed, intrauterine abnormalities. There is no information on any type of other pathology, such as intramural or subserosal fibroids, adhesions, convolution and phimosis of fallopian tubes, and endometriosis.

One should not forget that the “diagnostic” laparoscopy often changes into a therapeutic one. One-quarter of primary infertility patients and one-half of secondary infertility patients in the reported series benefited by laparoscopic correction of the pelvic pathology. Patients with normal findings undergoing the procedure benefited as well. Knowing that no detectable anatomical pathology was found in the pelvis allows for more efficient therapies to be resorted to more quickly.

In our experience the laparoscopy should be readily available not only to patients with a history of events which might cause problems in the pelvis but also to those who have been exposed to the possibility of conception for a reasonable length of time without success. The laparoscopy should be performed by a skilled and experienced laparoscopic surgeon who must be highly observant of any type of findings in the pelvis, such as atypical endometriosis and gross appearance of the ovaries, taking note of all signs of ovulation activity for the current cycle as well as previous ones, etc.

The rate of complications in both diagnostic and therapeutic laparoscopy and hysteroscopy should be low. Our own experience of 28 laparoscopic years was

positive, having had no patient with significant or even fairly significant complications.

Finally, one should not forget the additional benefits of laparoscopic inspection of the abdominal cavity. During our years of laparoscopy, we have found a few patients with unsuspected abnormalities of the liver, diaphragm, pancreas, and colon.

REFERENCES

1. Hovav Y, Hornstein E, Almagor M, Yaffe C: Diagnostic laparoscopy in primary and secondary infertility. *Assist Reprod Genet* 1998;15:535-537
2. El-Minawi MF, Abdel-Hadi M, Ibrahim AA, Wahby O: Comparative evaluation of laparoscopy and hysterosalpingography in infertile patients. *Obstet Gynecol* 1978;51:29-34
3. Sowden EU, Jarrett JC, Dawood MY: Comparison of diagnostic accuracy of laparoscopy, hysteroscopy and hysterosalpingography in evaluation of female infertility. *Fertil Steril* 1984;41:709-713

Jaroslav J. Marik

Tyler Medical Clinic

and

Department of Obstetrics and Gynecology

University of California

Los Angeles, California 90024