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 1980 s of the computer - chip television camera, which allowed videolaparoscopy to be performed ***(Stellato, 1992).***

The introduction of laparoscopic cholecystectomy by ***Mouret in 1987*** probably represents the most significant changes in general surgical technique this century ***(Mofti et al. 1994).***

The indications for laparoscopic cholecystectomy are the same as for a standard cholecystectomy, these include symptomatic gall stones and complications of gall stones such recurrent episodes of pancreatitis ***(Gadacz et al., 1990).***

Morbid obesity, acute cholecystitis, prior abdominal operation, intraabdominal adhesion and minor bleeding disordered, were considered as relative contraindication for laparoscopic cholecystectomy. Now they can be operated upon without hazards, depending on experience and special training of the surgeon ***(Sackier et al., 1992).***

However, laparoscopic cholecystectomy has rapidly become the procedure of choice for most patients with symptomatic gallbladder disease *(Zucker et al., 1992)*.

AIM OF THE WORK

The aim of this work is to evaluate the various difficulties that met with during laparoscopic cholecystectomy and the procedures to be done to deal with these difficulties away from reverting it to open cholecystectomy.