



## **Tubal Obstruction**

Tubal obstruction may occur in any part of the tube. The obstruction can be proximal (near the uterus), distal (away from uterus), or in the middle of the tube.

Proximal tubal obstruction or PTO can be due to spasm of the tube, or from a condition called salpingitis isthmica nodosa. Distal tubal obstruction is sometimes called a fimbrial obstruction and can be caused by pelvic infection or endometriosis. Mid tubal obstruction is the result of a tubal ligation or the removal of a tubal pregnancy.

The treatment of a tubal obstruction is surgery. Most proximal tubal obstructions can be cleared by passing a small catheter through the uterus and into the tube. This is called a hysteroscopic tubal cannulation. Interventional radiologists can also pass a catheter using fluoroscopy, a procedure called radiologic transcervical tubal cannulation. If severe scar tissue is encountered, the diseased part of the tube needs to be resected and the tube rejoined using microsurgery. Successful pregnancies can occur in 40-50% of patients.

Distal tubal obstruction may be opened using laparoscopic surgery. The procedure is called a fimbrioplasty or a salpingoplasty. The long term success rate with this surgery is about 20-25% and tubal pregnancy rates are 5-10%.

A tubal reversal is an open abdominal surgery. The tubes are rejoined using magnification, usually a surgical microscope, and microsurgery techniques. This is called a tubal anastomosis. The success rates depend on the final length of the tube and the exact location of the anastomosis, but approach 60-80% chance of pregnancy.

The other approach to treating tubal obstruction is In Vitro Fertilization (IVF). IVF success rates are decreased if there is a distal obstruction resulting in a fluid filled tube (hydrosalpinx). This tube should be occluded at the proximal part or be removed before IVF.