From Figure 1 it will be seen that the internal hernial contents in the intrasigmoid hernia push cranially, and rectal examination results were thus normal. In the second case, the contents lie caudally in the pelvis and, not surprisingly, a mass was felt rectally in the pouch of Douglas. Second, operative findings in the first case revealed a lax neck to the hernia, leading to a large congenital fossa. The patient gave a history suggestive of subacute obstruction, and laparotomy was delayed some 48 hours. Even then, the hernia was easily reduced and the contents found viable. On the other hand, the patient with the transmesosigmoid hernia was obviously acutely obstructed on admission, and laparotomy was not delayed. The defect in the sigmoid mesocolon was small , and the herniating small bowel was gangrenous, requiring resection (Fig. 2).

The surgical management of internal hernia in general is simple, as long as the diagnosis is considered and laparotomy performed early. The contents should be reduced, viability assessed, and the defect closed. With proper management, the mortality rate should be low.

References

1. Fredell CH. Intestinal obstruction due to unusual hernia. Arch Surg 1959;78:96–7.
2. Hansmann GH, Morton SA. Intra-abdominal hernia: report of a case and review of the literature. Arch Surg 1939;39:973–86.
3. Harrison BF Jr, Cheek JH. Intersigmoid hernia: review of the literature and report of an additional case. Texas J Med 1951;47:776–9.
4. Benson JR, Killen DA. Internal hernias involving the sigmoid mesocolon. Ann Surg 1964;159:383–4.

Announcement

ENTEROSTOMAL THERAPY TRAINING PROJECT

THE WORLD COUNCIL OF ENTEROSTOMAL THERAPISTS (established 1978), Milan, Italy, is the International body of Professional Nurse Specialists caring for patients with intestinal stomas. The members of this council are pledged to ensure that all patients undergoing stomal construction shall have the expertise of a qualified stomatherapist from the pre-operative period, during hospitalization and, for as long as necessary in the community.

At national level, each country has set down criteria for undergoing specialized training. The World Body has correlated each of the existing programs in order to advise any center wishing to establish a training program in accordance with the basic requirements.

Research by both the World Council of Enterostomal Therapists and the International Ostomy Association has shown that many centers practice stomal surgery without the expertise of a stomatherapist as an integral part of the patient's rehabilitation. There are only 24-member countries of the World Council, and some of these have not yet established a formal training program in enterostomal therapy.

The World Council would like to render practical assistance to rectify the situation by encouraging each center to run a program in accordance with the Council's basic requirements. The basic program content is readily available for the surgical and nursing staff to adapt to their needs. The World Council is also happy to provide a trained enterostomal therapist to conduct the practical aspects of the course for the first program and to assist in all ways to ensure the success of the venture. The Council will also assist in placing a trainee in a recognized stomatherapy program existing in a member country.

For additional information contact Priscilla J. d'E Stevens SRN ET, President: WCET, Department of Stomatherapy, Groote Schuur Hospital, Cape Town, South Africa.