

der area and a grid iron abdominal wall incision, the Spigelian hernia was located after splitting the external aponeurosis. The hernial orifice was small, the edges were well defined and rigid. The contents included preperitoneal fat surrounding a peritoneal sac and a neurovascular bundle. The hernial orifices were enlarged, the sac was opened and abdominal viscera inspected and palpated. The sac was excised and hernia repaired using nonabsorbable monofilament nylon sutures. The post-operative period was uneventful. Following discharge at follow up 1 year later, he was asymptomatic, free of pain and there was no recurrence of the hernia.

Protrusion of a preperitoneal fat, peritoneal sac or an organ from its normal position through a defect in the Spigelian fascia is referred to as a Spigelian hernia. Most such lesions are acquired, small, non-palpable and located below the umbilicus between the parietes. The hernial orifice is usually oval or round, and the edges are well defined and rigid. Neurovascular bundle from the intercostal vessels and nerves may have natural openings in Spigelian fascia created by their anterior cutaneous branches. Enlargement of such neurovascular opening as a predisposing factor has been reported earlier and finding of neurovascular bundle in the hernial orifice of our patient also supports this theory(2).

It is generally difficult to clinically diagnose Spigelian hernia because of non-specific symptoms and the often intramural location of the hernia beneath an intact external oblique aponeurosis(3). Distinct tenderness over the hernial orifice is not pathognomonic of Spigelian hernia but offers a useful method for screening. Cross table ultrasonographic examination or computerized tomographic scanning of the abdominal wall may allow early

diagnosis(4). The results of surgical repair are excellent and the risk of recurrence is low(5).

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Neonatal Branding—Towards Branding Eradication

It was interesting to read the article on neonatal branding by Mohapatra(1). We agree with the author that this is a hazardous practice and steps should be taken at all levels to discourage this. In our hospital we have started maintaining an accurate record of branding cases in a 'Branding

Register' since 1982 onwards. The annual incidence of branding is shown in *Table I*. A cursory analysis in the first year of registry showed that this inhuman practice was prevalent in rural areas among illiterate people having superstitions for minor problems in children such as abdominal colics, bronchopneumonia, hydrocele, general ill health and failure to thrive. Since 1982, we have had 3 deaths due to the complications following branding and 18 cases who survived due to intensive care had septicemia. One female neonate having hydrocolpos developed septicemia following branding and had pyocolpos(2).

Table I shows a progressive decrease in the incidence of branding cases following various measures described below.

(1) *Public health education*: Through local, regional and national newspapers and magazines, radio talks and television interviews.

(2) *Provision of better health services*: Vaccination programmes and other child welfare programmes were intensified in the regions from where more cases were coming. The Primary Health Centre's Medical Officers and Paramedical staff in-

cluding field workers are encouraged to be aware of the branding practice in their villages and they must also report the same to higher authorities.

(3) *Social and political resources*: Village heads, school teachers, religious leaders and volunteer services were educated to explain to branders to give up branding and increase public awareness to discourage this practice by various social and political sanctions against them.

(4) *Administrative and judicial actions*: Branding is a criminal offence under Indian Penal Code-324. Our hospital had filed 3 court cases of deaths in whom the Judicial Magistrate had ordered a police inquiry and conducted the court trial.

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TABLE I—Incidence of Neonatal Branding

Calender year	Number of cases
1982	96
1983	74
1984	58
1985	25
1986	36
1987	14
1988	18
1989	17
1990	16
1991	17

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Modified Rubner's Test: Diagnosis of Secondary Lactose Intolerance Diarrhea

Transient carbohydrate intolerance, especially lactose, is emerging as an important cause of diarrhea, particularly in children below 2 years of age(1,2). No simple and reliable diagnostic laboratory method is presently available for the accurate diag-