A patient does not acquire an intestinal stoma by choice, but as a result of circumstances forced on him by disease or injury. A colostomy often arouses a patient's insecurities, apprehension of social discrimination, or the fear of disease and death. Therefore, it is of utmost importance for the surgeon to lighten the weight of the loss of the rectum by giving the patient the best possible stoma. Even a minor problem can assume monumental dimensions in the mind of the patient. A surgeon should take all the time necessary to construct a stoma that works effectively and has minimal long-range problems.

In this paper, we discuss umbilical colostomy, which has given us extremely good results. We feel that a mature umbilical colostomy has distinct advantages, and therefore recommend its use.

The first recorded spontaneous umbilical colostomy was that of Margaret White, of Surrey, who had an umbilical hernia that strangulated and was followed by perforation and establishment of a colostomy, a case reported by William Cheseldon of London in 1750. The first suggestion of deliberate colostomy was made by Alexis Littré in 1710, and a cecostomy was done by Pillore of Roun in 1776. The first iliac colostomy was done by C. Durat of France in 1793. Amussat, in 1839, introduced the first lumbar colostomy (Table 1). In 1908, Ernest Miles (Table 1) introduced end colostomy by his surgical procedure of combined abdomino-perineal resection. Hirschman started the procedure of umbilical colostomy in this country, and this has since been done in various centers.

We now have done this procedure in our practice for the last seven years, and we feel a review of our experience may be worthwhile.

**Material and Method**

There were 106 cases in which umbilical colostomy was done by the authors between January 1969 and May 1976 (Table 2). Four patients died in the postoperative period, and one was lost to follow up. Therefore, 101 cases were available for review.