REFERENCE

1. Dhawan A, Marwaha RK. Acute glomerulonephritis in multidrug resistant *Salmonella typhi* infection. Indian Pediatr 1992, 29: 1039-1041.

Reply

We thank Dr. Srivastava for his interest in the case report of acute glomerulonephritis in typhoid fever(1). Reasons beyond our control precluded a renal biopsy. The absence of confirmatory histological findings naturally generates controversy regarding the renal pathology. We would like to reiterate that the presence of red cell casts in the urine and the low serum C3 give credence to a glomerular lesion. Sitprija *et al.*(2) were able to demonstrate immune complex glomerulitis in three unselected cases of typhoid fever with no clinical or laboratory evidence of renal dysfunction and postulated a direct role of *S. typhi* in the pathogenesis of the glomerular lesion. If this is true, then recovery in renal function could parallel the amelioration of other symptoms and signs as was observed in the case reported. We accept criticism of the obvious omission in our case but it may prompt a systematic evaluation of the pathogenetic mechanism(s) of renal dysfunction in typhoid fever and of the course and pattern of recovery in cases with renal failure.

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1. Dhawan A, Marwaha RK. Acute glomerulonephritis multidrug resistant *Salmonella typhi* infection. Indian Pediatr 1992, 29: 1039-1041.
2. Sitprija V, Pipatanagul V, Boonpucknavig V, Boonpucknavig S. Glomerulitis in typhoid fever. Ann Int Med 1974, 81: 210-213.

Trichuris Dysentery

Infection with whipworm, *Trichuris trichiura* is one of the commonest helminthiases of childhood. In tropical countries where other diseases obscure the source of symptoms, this parasite is usually more or less ignored, with the assumption that it is non-pathogenic(1). That such is not always true is being demonstrated by the following case report.

A five-year-old male child was admitted with history of prolonged diarrhea with blood streaked stool, abdominal pain, tenesmus for the last 3 years. The child had suffered from generalized swelling of the body two years back for which he had received three bottles of blood transfusion. He was also suffering from rectal prolapse. Apart from this, the child was treated outside also with metronidazole, cotrimoxazole, furazolidine, nalidixic acid and Inj. emetine without any appreciable result.

Physical examination revealed a moderately anemic child with weight of 14 kg, height 100 cm and mid-arm circumference 13 cm. No edema or clubbing was observed. Abdominal examination showed