size to conclude that the 2 therapies were equivalent. They found that all the studies were either of flawed design, inadequate follow-up, inadequate number of patients, were not double blind, suffered from inadequate patients selection or were in some other way methodologically flawed. They unequivocally concluded that there was inadequate data to recommend short course therapy for UTI in children.

It is, therefore, recommended that short course therapy should not be used in children till further evidence is available that it is as effective as conventional treatment(6).

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Comment

Single dose treatment for urinary tract infections is attractive because it is associated with improved compliance and reduced side effects and cost. This therapy was used successfully in treating *lower* urinary tract infections in adolescent girls(1), children and adults(2). However, at present, there is no practical and reliable, clinical or laboratory technique to differentiate upper from lower urinary tract infections. Others have found that, while many children do respond satisfactorily to treatment, recurrences of infection after 10 days were more likely to occur after single dose therapy than an one-week course(3). A meta-analysis of previously reported studies concluded that there was insufficient evidence to recommend the use of short course antibiotic therapy for urinary tract infections in children(4).

In would be prudent to restrict single dose treatment to adolescent girls with normal urinary tracts, where the risk of renal damage is low. However, younger children and those with abnormal urinary tracts, fever or urinary tract symptoms must be treated with appropriate antibiotics for 7-10 days(5).

The other controversy, regarding therapy for asymptomatic bacteriuria, seems to be almost resolved. Asymptomatic bacteriuria, often diagnosed on routine screening of urine in school girls, represents a continuous infection with organisms of low pathogenicity. Treatment with antimicrobials appears to have no effect on emergence of symptoms of growth of kidneys. On the contrary, following antibiotic therapy, reinfection with new organisms is rapid and often more damaging to the

kidney than the original low grade bacteriuria. Asymptomatic bacteriuria is considered to be a benign condition in school girls(6), and need not be treated.

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Progeria

I was interested to read the recent report on Progeria. The authors refer to coronary heart disease as the cause of death. In this context, I would like to briefly report about the case of Progeria which we followed from age 7 years till her death due to coronary heart disease at the age of 15½ years in 1971. She weighed 10.9 kg and her height was 109 cm. She complained of episodes of left chest pain with radiation to the left shoulder for about a month accompanied by sweating. There was no cardiomegaly, the heart sounds were normal and there was no evidence of congestive heart failure. ECG showed depression of ST segment in precordial leads. SGOT and SGPT was 32 K units and 12 K units, respectively. She was treated symptomatically but expired at home during an episode of severe precordial pain accompanied by profuse sweating and shock.

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Multiple Giant Mesenteric Cysts

Multiple mesenteric cysts involving the complete small bowel mesentery are rare. In fact, Colodny(1) could find only one such case from their records over 50 years. We report a similar case where we could excise multiple mesenteric cysts of various sizes completely with only a limited resection of adjacent proximal jejunum.

A five-year-old male child was admitted with acute abdominal symptoms of 5 days duration. Physical examination revealed a well defined cystic mass measuring 10 × 8 cm with minimal mobility in the transverse axis. Ultrasonography suggested a diagnosis of mesenteric cyst. On explora-