

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-

tion, the child was found to have multiple large mesenteric cysts involving the whole of the small bowel mesentery. The small bowel itself did not have any features of lymphangiectasia. A dissection of individual cysts was done while preserving the vascularity of the adjacent small bowel. A few cysts allowed easy blunt dissection, as a plane of loose areolar tissue could be obtained after opening the peritoneal layer of the mesentery. Most of the cysts, however, required opening the individual cyst wall and removal of the endothelial lining. In one area, the mesenteric cyst was densely adherent to the proximal jejunum and its blood supply. This necessitated excision of the adjacent bowel with an end to end anastomosis. The post-operative period was uneventful.

Mesenteric cysts are symptomatic in two third of cases and hence require surgical intervention. Localized mesenteric cysts may be treated by total resection. Frequently these cysts lie in intimate contact with the bowel which may require resection of the attached bowel along with the cysts. Total excision is seldom possible in the rare occurrence of multiple cysts occupying the whole of the small bowel mesentery(1).

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Tuberculosis in a BCG Vaccinated Child with Leprosy

Leprosy is widely prevalent in adults in India, with prevalence rate of 5.7 per 1000(1) but is uncommon in childhood(2). However, tuberculosis is widely prevalent in both adults and children. Occasionally the two conditions may occur together posing problems in diagnosis and therapy(3-5). We report a 5-year-old patient who had received BCG vaccination and later developed leprosy and tuberculosis.

A 5-year-old boy presented with well defined hypopigmented macules over the left leg, elbow and arm of two year duration and a recent appearance of an erythematous plaque on the right nasal alae. The hypopigmented macules showed erythematous infiltration over the next 4 months. He was normally built for his age; there was no lymphadenopathy or enlargement of the liver or spleen. The right ulnar nerve was thickened and tender and the popliteal nerves were palpable. Fine touch, pain and temperature sensations were impaired on the involved region. The father and aunt were suffering from borderline tuberculous leprosy. The child had received BCG vaccination. On investigation, the hemogram showed a hemoglobin of 10 g/dl and a total WBC count of 9700 cells/cu mm with 62% lymphocytes. The tuberculin test performed with 5 tuberculin units was positive (30 × 25 mm). Chest roentgenogram showed bilateral parenchymal lung infiltrations, along with hilar lymphadenopathy. The skin biopsy from lesions on the leg showed border line tuberculoid (BT) histology consisting of diffuse epithelioid-cell infiltrate in the dermis and few lymphocyte infiltrate. Smear examination for acid fast bacilli was negative. The child recovered well with simultaneous administration of