due only to the pressure of the mass on the diaphragm. The patient was discharged on the twelfth postoperative day.

The resected specimen measured 18 × 12 × 10 cm and weighed 1.1 kg. The cut surface was greyish white in most of the areas with scattered yellowish regions in between. On histological examination sections showed a matured teratoma containing tissues of skin and its appendages, brain, muscle, cartilage, choroid and respiratory epithelium.

The prognosis of gastric teratoma is very good. Patients died of gastric teratoma only in those cases who had not been operated or who had suffered hemorrhage and vomiting or reached the treatment moribund. A difficulty may arise in clinical diagnosis. It is so rarely encountered that in none of the reported cases gastric teratoma was diagnosed preoperatively. In our case the presence of irregular calcified areas in the *X*-ray was suggestive of teratoma, but its site of origin could only be ascertained on laparotomy.

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Autoimmune Hemolytic Anemia–Mixed Type

A six-year-old girl was admitted with generalised weakness, recurrent episodes of palpitation with dyspnea and severe pallor. There was no history of blood loss or jaundice. She had received treatment for fever 6 days prior to admission. Examination revealed severe pallor but no icterus, petechiae or purpurae, puffiness or significant edema. Her firm liver spanned 12 cm and spleen was palpable 6 cm below the costal margin. There was moderate cardiomegaly, with a hemic murmur. The other systems were normal.

Blood examination showed: hemoglobin 4.5 g/dl, hematocrit 15%, reticulocyte count 4% (corrected 1.5), normal leukocyte and platelet counts. Liver functions, serum iron and iron binding capacity were normal. Direct and indirect Coomb's tests were strongly positive. Antibody studies revealed presence of both cold (4°C) and warm (37°C) antibodies both in enzyme and saline preparations. The serum

complement and immunoglobulin levels were normal.

A diagnosis of Immune Hemolytic Anemia (IHA) (mixed antibody type) was made. The child was treated with prednisolone (2 mg/kg/day) and folic acid (1 mg/day). Response to this therapy was excellent. The hemoglobin rose steadily and the reticulocyte count increased as high as 20% before returning to normal. The antibody levels at 6 weeks were still positive but returned to normal at 3 months.

Immune hemolytic anemia (IHA) is a well known entity. Most cases are having cold agglutinin(1), low serum complements and presence of anti-C_3b component. Few patients having warm agglutinin have reduced IgG levels. Less than 5% of all cases are of mixed type and this type is even less common in children(2). Our patient was of the mixed type and yet had neither a reduced complement level, nor decreased immunoglobulins. No clue to the etiology could be found. However, as is well known in the acute type, this patient responded to corticosteroids and supportive management(3).

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NOTES AND NEWS

PEDIATRIC NEPHROLOGY SUBSPECIALITY CHAPTER

Those members of IAP who wish to join the Pediatric Nephrology Subspeciality Chapter of IAP are requested to send their application with the biodata to Dr. Kumud P. Mehta, Convenor, Pediatric Nephrology Subspeciality Chapter of IAP, Bai Jerbai Wadia Hospital for Children, Nephrology Division, Parel, Bombay-400 012. The cheque for life membership (Rs. 500/-) is to be drawn in favour of "Indian Pediatric Nephrology Group (IPNG)". (This includes quarterly Newsletter of IPNG).