attenuation of prostatic tissue seen in congenital obstructions leads to loss of obliquity of the normal ejaculatory ducts as they enter the posterior urethra. Associated distal obstruction to the flow of urine may aid in the urethro-ejaculatory reflux of urine .If the urine is infected, this precipitates epididymo-orchitis as it happened in the index case. However this reflux must be very unusual as epididymo-orchitis is a rare association in PUV.

Epididymo-orchitis is uncommon in children and is indicative of an underlying abnormality of the urinary tract, usually a pathological connection between the urinary system and the genital duct system or the bowel(2,3). Any pre-pubertal child with epididymitis merits a complete urological evaluation including urine culture, voiding cysto-urethrography and excretory urography. Surgically treatable conditions ectopic ureters opening into seminal ducts, ectopic vasal insertion into the bladder, and recto- urethral fistulas have been picked up on screening children of epididymo-orchitis. Hence pediatricians encountering a child with epididymo-orchitis must exclude underlying surgical problems in the baby which are treatable(2,3).

Narasimhan KL,
Alka Gupta,
Department of Pediatric Surgery, PGIMER, Chandigarh 160 012, India.
E-mail: narasimhankannan@hotmail.com

REFERENCES

1. Kupfermann JC, Steward CL, Kaskel FJ, Fine RN. Posterior urethral valves in patient with Down syndrome. Pediatric Nephrol 1996; 10: 143-146.
2. Siegel A, Snyder H, Duckett JW: Epididymitis in infants and boys: underlying urogenital anomalies and efficacy of imaging modalities: J Urol 1987; 138: 1100-1103.
3. Umeyama T, Kawamura T, Hasegawa A, Ogawa O. Ectopic ureter presenting with epididymitis in childhood: A report of 5 cases. J Urol 1985; 134: 131-135.

Bisphosphonate Therapy in Polyostotic Fibrous Dysplasia

I read with interest the article by Khadilkar, *et al*.(1), reporting their experience of treating a case of polyostotic fibrous dysplasia (PFD) with oral alendronate resulting in an improvement in bone mineral density (BMD) and a marked reduction in bone pain. However, I would like to make certain observations.

Firstly, the indications for using bisphosphonates in PFD have not been specified. Currently, bisphosphonates are recommended for symptomatic cases such as those with bone pain or recent fractures(2). The current evidence does not favor the use of bisphosphonates in asymptomatic patients as this therapy does not lead to refilling of dysplastic lesions in children and adolescents as opposed to adults(3). Also, it needs to be emphasized that treatment needs to be continued for a long period, such as a minimum of 18-24 months, before a significant improvement is observed.

Authors of the current paper propose that

oral alendronate is an effective alternative to intravenous pamidronate in treating patients with PFD. However, they have not mentioned about the only paper comparing intravenous and oral bisphosphonates in PFD(2). In the above-mentioned article, no differences were found in the favorable response to either oral bisphosphonates alone or in combination with intravenous therapy regarding bone pain and fracture healing. Therefore, lower cost and ease of administration are not the only reasons favoring the use of oral over intravenous bisphosphonates, but there are published reports too.

Concern has been raised regarding the safety profile of bisphosphonates in children as most of the experience has been obtained from their use in osteoporosis and Paget's disease that predominantly occur in adults. However, no serious side effects were noted in a recent study(3) conducted on 18 children and adolescents using pamidronate treatment for 1.2-9.1 years (median 3.8 years).

In conclusion, bisphosphonates are safe and effective in reducing bone pain and incidence of fractures in children with PFD. Oral alendronate is an effective alternative to intravenous pamidronate in this setting.

Kumar S.,
Neurology Unit,
Department of Neurological Sciences,
Christian Medical College Hospital,
Vellore, Tamilnadu 632 004, India.
E-mail: drsudhirkumar@yahoo.com

REFERENCES

1. Khadilkar VV, Khadilkar AV, Maskati GB. Oral bisphosphonates in polyostotic fibrous dysplasia. Indian Pediatr 2003; 40: 894-896.
2. Lane JM, Khan SN, O'Connor WJ, Nydick M, Hommen JP, Schneider R, et al. Bisphosphonate therapy in fibrous dysplasia. Clin Orthop 2001; 382: 6-12.
3. Plotkin H, Rauch F, Zeitlin L, Munns C, Travers R, Glorieux FH. Effect of pamidronate treatment in children with polyostotic fibrous dysplasia of bone. J Clin Endocrinol Metab 2003; 88: 4569-4575.

Neonatal Necrotizing Fascitis

We report two cases of necrotizing fascitis in the newborn.

Case 1: A 25-day-old full term normally delivered neonate presented with redness and swelling of occipital skin for one day. There was no history of trauma. Local examination revealed an 8 × 7 cm reddish patch over the occipital region. Within 24 hours the scalp showed patches of necrotic skin, discharging fluid and ulcers with slough on its floor. Pus culture grew streptococcus pyogenes while the blood culture was sterile. The infant was treated with parenteral antibiotics, debridement and subsequent skin grafting.

Case 2: An 11-day-old full term caesarean delivered neonate presented to us with necrosis over left occiput, right forearm and both legs. Local examination revealed two necrotic patches - over left occiput measuring 5 × 6 cm. Also a 5 × 4 cm lesion was present over the left dorsum of forearm with a well established line of demarcation (*Fig. 1*). The pus culture grew streptococcus pyogenes and the blood culture was sterile. The infant was treated with early debridement, intravenous