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should be radiographed to document calcification and exclude artefacts. (4) The infants with this benign condition don't need extensive radiographic evaluation. (5) A "string of pearls" sign per se need not indicate presence of multiple small bowel atresias.

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Table 5

Indications for ultrasound as the primary examination
Screening for genitourinary anomalies
Vague abdominal pain
Palpable mass
Renal failure
Possible complications of urinary tract infection
Indications where ultrasound plays a secondary role
Typical renal colic (usually in older children and adolescents)
Hematuria
Difficulties in micturition
Urinary tract infection – routine evaluation

Table 6

Potential causes of false negative ultrasound examinations
Acute obstruction
Rupture of collecting system
Bladder outlet obstruction
Dehydration
Potential causes of false positive ultrasound examinations
Bladder distension
Vigorous diuresis

amination, its limitations should be recognized. Significant obstruction may be present even with minimal or no dilatation of the collecting system. Situations in which sonography may be misleading are summarized in Table 6.

Summary

Sonography is an excellent screening procedure for hydronephrosis. Most patients with symptoms that are not specific for the urinary tract will not require radiographic procedures if the ultrasound study is negative [2]. The incidence of false positive examinations should be very low if bladder distension is checked during the study. Symptoms of bladder outlet obstruction are an indication for VCUG. The patient with renal failure and even minimal hydronephrosis may require further evaluation to exclude urinary tract obstruction.

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cial anomalies. Interposition of these bands between the apposing facial processes results in facial anomalies, such as hypertelorism, cleft lip and/or cleft palate. These facial clefts occur in bizarre, oblique planes that could not have simply resulted from intrinsic failure of the facial processes to appose.

The meningoencephalocele present in our case is asymmetric and unusual in location since this anomaly commonly occurs in the midline and occipital region. We postulate that a constrictive amniotic band along the developing right cranium of our patient resulted in protrusion of the brain and its coverings. The medial convexity of the right parietal bone is very likely explained by the pulsatile and expansive nature of this meningoencephalocele containing part of the dilated ventricular system.

The spectrum of manifestations of the ABDC result in misdiagnosis, hence incorrect recurrence risk counseling. Affected individuals have a common pathogenetic mechanism but are never quite alike since the timing of amniotic rupture and the extent to which fetal entanglement occurs is variable. There is no increased risk of recurrence in contrast to primary neural tube defects [4, 5]. The clinician and radiologist must recognize a pattern of malformations rather than a specific group of individual defects to identify the ABDC.

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three weeks following the initial presentation, cavities were still noted but were considerably diminished in size. A persistently enlarged aorticopulmonary lymph node was seen throughout the course of the patient's illness.

The primary site of infection in our patient was presumed to be the upper respiratory tract. The multisystem nature of the disease became apparent with intestinal, articular, and renal involvement, suggesting embolic foci. Radiographic studies of these regions were normal, however. Characteristically, symptoms and pulmonary radiographic findings demonstrated progression despite appropriate antibiotics. This prolonged clinical course may suggest the presence of superinfection or perhaps an underlying systemic disorder unless the natural history of *Fusobacterium* pneumonia is understood.

Although the radiographic findings in this condition are nonspecific, in a patient with multisystem manifestations, the development of a necrotizing pneumonia with a pattern suggesting septic emboli with pleural effusions should raise the consideration of *Fusobacterium* sepsis. Clinical and radiologic evaluation of the nasopharynx and sinuses may demonstrate underlying inflammatory disease. As anaerobic cultures may not be performed routinely in some centers, the astute radiologist with appropriate history may be the first to suggest the diagnosis.

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and gelatinous mucoid-filled cystic structures. Two teeth also were identified. On microscopic examination, there was no evidence of malignancy in any of the cell lines and no signs of adjacent pneumonia. Final diagnosis was benign mediastinal teratoma.

Discussion

Teratomas typically are located in the anterior-superior mediastinum, and when calcifications or teeth are present, the diagnosis is assured. Occasionally, fat may also be recognized on plain chest radiographs, although computerized tomography is the most effective technique for demonstrating both fat and calcification. Virtually all these findings were present in our patient, strongly suggesting that this lesion was a teratoma. The presence of hemoptysis represented an unusual presentation of intrathoracic teratoma and raised the possibility that the teratoma had malignant components. Angiography did not rule out this possibility, although it did show that the bleeding was secondary to systemic to pulmonary artery shunts.

Systemic to pulmonary artery shunts in childhood most commonly develop from chronic pulmonary infection, and in this regard, cystic fibrosis is the commonest cause. In these cases, the chronic infection leads to decreased pulmonary artery perfusion and parasitization of blood flow from the systemic circulation [4]. The specific cause for systemic to pulmonary artery shunting in our patient, however, is unclear. It is possible that the chest trauma sustained three months prior to surgery resulted in rupture of the tumor and subsequent formation of the vascular pleural adhesions. On the other hand, the tumor may have bled without rupture, in that systemic to pulmonary artery shunts have been documented after spontaneous fistula formation [2]. The fistulae, in these cases, arose after infection or from the secretion of digestive juices from intestinal tissue in the tumor [5]. No such fistula, however, was demonstrated in our case. No signs of chronic pneumonia and/or bronchiectasis leading to neovascularity and systemic to pulmonary artery shunting were noted. In the end, only the chest trauma occurring three months prior to admission could be incriminated as a cause of adhesions and systemic arterialization of the tumor.

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tion as a cause for gastrointestinal blood loss, since many patients with ileal dysgenesis, as well as those with duplications, have ulceration in the malformation without the presence of acid-producing mucosa.

Short stature with catch-up growth after excision has not previously been described in a patient with ileal dysgenesis. We are uncertain of its mechanism, especially in light of our failure to document bacterial overgrowth in, or distal to, the dilated segment.

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Book reviews

N.S. Rosenfield. The Radiology of Childhood Leukemia and Its Therapy. St. Louis: Warren H. Green, Inc. 1981/1982. 33 figures, 9 tables 112 pp, $ 22.50. ISBN 87527-173-1

The fact that this book is already in its second edition is a reflection of its relevance. The relevance of the material is based on the enormous progress that has been made in the therapy of leukemia. The healing period is burdened with complications and side effects which present special problems for the pediatrician, oncologist, and roentgenologist.

The first part deals with all early findings, those before diagnosis and therapy. The transverse bands of decreased density, generalized and focal osteolysis, subperiostal new bone formation, and osteosclerosis are described as the most important skeletal symptoms. The aforesaid bands are termed "leukemic lines" since, unlike in infancy, they are almost pathognomonic in children of school age. Leukemia leads to a roentgenological enlargement of the organ involved; those most frequently affected are the spleen, kidneys, liver, thymus, and the chloroma in the frontal skull. Organ enlargement in the epigastrium can also be recognized and measured by sonography. The pneumencephalograms reproduced in the chapter "Meningeal leukemia" seem rather out of date and should be replaced by computer tomograms. Intestinal changes are discussed in the chapter "Pneumatosis intestinalis and typhlitis." Uric acid nephropathy concludes the first part of the book. The second part on complications covers side effects on the skeleton, heart (vincristine and adriamycin), lungs (congestion), intestine (ileus), bladder (hemorrhagic cystitis), and the methotrexate effects on the bones, lungs, and liver, as well as the effects on the skull in combination with irradiation of the central nervous system. These effects are illustrated by radiograms and computer tomograms. There is no mention of the nonspecific infections caused by immune depression.

The text is brief but concise and there are plenty of well-produced illustrations. Clinical and pathological material is discussed in separate sections and provides the link to radiology, sometimes using tables. Each chapter has a reference list.

This book deserves attention. It is the best work of its kind on this subject and is to be recommended as a good monograph on a subject which should be of particular interest to pediatricians, oncologists and pediatric radiologists. Moreover, the price is very reasonable.

E. Willich (Heidelberg)

Announcements and news

The *27th Annual Meeting of the Society for Pediatric Radiology* will take place from 6–8 April 1984. It will be preceded by a course on Digital Radiography and NMR in Pediatric Imaging. The course will take place on 5 April 1984. There will be a fee for attendance, to cover the expenses of the course. The course and annual meeting will take place at the Las Vegas Hilton Hotel. Our meeting will come before the American Roentgen Ray Society at the same hotel.