On the basis of their results, the authors suggest that a sitting height:leg length ratio of <0.83 indicates a diagnosis of SIOD, whereas a ratio of >1.01 indicates the presence of chronic kidney disease secondary to another disease.

Original article Lücke T *et al.* (2006) Schimke versus non-Schimke chronic kidney disease: an anthropometric approach. *Pediatrics* **118:** e400–e407

Lack of glomerular deposits signals a better prognosis in AA amyloidosis

A number of patients with chronic inflammatory conditions, such as rheumatoid arthritis (RA), develop amyloid A (AA) amyloidosis, a condition characterized by the extracelluar deposition of serum AA protein-containing fibrils. Renal involvement is frequent. Many patients develop end-stage renal disease by the time AA amyloidosis is confirmed, resulting in a poor prognosis. Researchers working in Japan have, however, identified a group of patients with RA who retained normal renal function for more than 5 years following diagnosis of AA amyloidosis.

In a prospective study, Uda *et al*. examined the relationship between renal function and amyloid deposition in the kidneys of 38 patients with AA amyloidosis. All patients had received a diagnosis of RA more than 5 years previously and had normal renal function at the time that AA amyloidosis was diagnosed. From renal biopsy results, the researchers identified two distinct amyloid deposition patterns: deposition in glomeruli, with or without deposits around blood vessels (type 1, 27 patients); and deposition solely around blood vessels (i.e. no deposition in glomeruli; type 2, 11 patients). During 5 years of follow-up, the renal function of patients with type 1 amyloid deposition deteriorated rapidly, and most commenced hemodialysis. By contrast, patients with type 2 amyloid deposition did not exhibit a marked deterioration in renal function during follow-up and none began dialysis. Patients with type 1 amyloid deposition had a 5-year survival rate of only 41.2% from the point of AA amyloidosis diagnosis, compared with 90.9% for patients with type 2 deposition.

Original article Uda H *et al.* (2006) Two distinct clinical courses of renal involvement in rheumatoid patients with AA amyloidosis. *J Rheumatol* **33:** 1482–1487

Child-to-child transplantation yields better long-term renal graft function

Pediatric donor kidneys are frequently not allocated to children because a number of historical studies have indicated that these grafts are less likely to survive than grafts from adult donors. Conversely, other studies have shown that the glomerular filtration rate of renal allografts from adult donors drops following transplantation into a pediatric recipient, and subsequently fails to increase as the child grows.

Researchers at the Medical School of Hannover, Germany, followed 99 white children (mean age 5.5 years) who received a first cadaveric kidney transplant during the period 1990–2005; 60 children received a graft from an adult donor (mean age 36 years) and 39 received a kidney from a pediatric donor (mean age 9 years). During the first 15 years of follow-up (mean follow-up period 5.9 years) no difference in graft survival was noted between the two groups. Grafts from pediatric donors, although smaller at the time of transplantation, increased in size following the procedure, and reached volumes similar to those of kidneys from adult donors within 3 years. The estimated glomerular filtration rates, adjusted to recipient body surface areas, of grafts from pediatric donors were considerably higher 3–5 years after transplantation than those of organs donated by adults.

The investigators suggest that renal allografts from pediatric donors over 2 years of age should be preferentially allocated to pediatric recipients matched for age and body size.

Original article Pape L *et al.* (2006) Superior long-term graft function and better growth of grafts in children receiving kidneys from paediatric compared with adult donors. *Nephrol Dial Transplant* **21:** 2596–2600

Children with a single, normal kidney can participate in contact/collision sports

Consensus is lacking among medical professionals as to whether children and adolescents with a single, normal kidney should participate in contact/collision sports; faced with confusing guidance, many advise against participation. Contrary to this opinion, Grinsell and colleagues at the University of Virginia declare