necrosis after perinatal shock, renal dysplasia in prune belly syndrome, neonatal Shiga toxin-associated hemolytic uremic syndrome, and bilateral nephrectomy in autosomal recessive polycystic kidney disease.

Results and Discussion: Initially, 3/4 patients were started with HDF. Reasons were abdominal surgery in two patients and presumed acute renal failure in one patient. Thereafter all patients were switched to PD. If complications occurred on PD, patients were switched back to HDF. In case of severe volume overload we started with cHDF and continued with iHDF. During the first year of life, 3/4 patients required 1 to 3 HDF rescue treatment periods (major abdominal surgery in 5 periods, recurrent peritonitis in 1 period). 1/4 patients had to be switched to maintenance iHDF due to multiple abdominal leaks at 8 months of age. All 4 patients survived the first year of life. One patient is on maintenance PD at 23 months. Two patients were transplanted successfully at 22 and 35 months, respectively.

In conclusion, in case of complications on PD, HDF is an option to achieve long-term survival and kidney transplantation.

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ONE YEAR CLINICAL EXPERIENCE WITH THE PRISMAFLEX HF 20 SET IN FOUR INFANTS

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Objective: We present the first clinical report involving use of the Prismaflex (Gambro) with the newly developed Prismaflex HF20 Set in 200 consecutive treatments for patients with end-stage renal disease (ESRD).

Patients: Four infants with ESRD (ages of 13, 10, 5, and 25 months, and with a body weight of 9.5 kg, 8.5, 6.5, and 9.5 kg, respectively) were treated with intermittent hemodiafiltration (HDF). All patients received five hour treatments. Treatment monitoring included weight change and fluid balance of

patients, the efficacy of treatment, the number of interventions, and machine alarms.

Results: We used blood flow rate 50 ml/min, dialysate fluid rate of 1000 ml/h and replacement fluid rates of 500 ml/h. Based on the precision of the Prismaflex scales, desired fluid balance was achieved according to the prescribed weight loss for the patients. The efficacy of treatment was monitored by BUN and creatinine values (55 ± 20 mg/dl and 5.3 ± 1.0 mg/dl, respectively) at start of treatment and their decrease after 4 hours of RRT (21 ± 8 mg/dl and 2.2 ± 0.6 mg/dl, respectively). At the start of treatment, urea and creatinine clearances were 23.3 ± 7.0 ml/min and 19.1 ± 4.4 ml/min, respectively. No complications during the HDF occurred.

Conclusion: This is the first report about the use of the Prismaflex HF20 Set in infants with ESRD. No side effects were detected, treatments were tolerated well in all patients, and adaptation of the flow rates to the infants' needs was good.

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NEPHROLITHIASIS DUE TO IDIOPATHIC HYPERCALCIURIA IN A 12 YEAR OLD BOY: CASE REPORT

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Introduction: Nephrolithiasis is recognized increasingly in children and inherited metabolic diseases are identified more frequently in children than in adults. The evaluation of a child with nephrolithiasis should be directed towards identifying physicochemical, anatomic and genetic factors predisposing to nephrolithiasis. Hypercalciuria is the most common metabolic cause of pediatric urinary calculi. In children with hypercalciuria the prevalence of urolithiasis in the family is 46-69%.

Methods: There is described the case of a 12-years-old non-Greek boy with short stature and history of recurrent nephrolithiasis since the age of 4 years old without further evaluation. Endocrinology tests for GH were normal and the bone age was markedly delayed. The kidneys ultrasound showed expanded nephrolithiasis. Hypercalciuria and hypocitraturia were revealed with normal serum calcium concentrations. In 24 hours urine collection, oxalate was normal. PTH was normal. Bone mineral density was decreased.