due to anti-phospholipid syndrome but was most likely a result of hypercoagulable state in nephrotic syndrome (membraneous nephropathy) in SLE. RVT in SLE occurs in 40% of affected children. Pulmonary embolism is rare in childhood (incidence 0.9/100 000). However, it is the second most frequent thromboembolic complication of nephrotic syndrome in children and was found in 25–30% of children who underwent systematic ventilation–perfusion scintigraphy.[1] The treatment should consist of anti-thrombotic agents alongside with immunosuppressive drugs. In children over 2 months of age with an initial thromboembolism, treatment with intravenous heparin or LMWH is recommended. Continuing anticoagulant therapy is suggested for at least 6 months using vitamin K antagonists, or alternatively LMWH. Treatment needs to be individualised. Thrombolytic therapy is recommended only in cases of bilateral RVT with various degrees of renal failure.[8] Intravenous heparin can be also combined with AT-III concentrate.[1,7] Long-term anticoagulation with oral warfarin has been also reported as beneficial in paediatric SLE patients.[3] In conclusion, thromboembolism can be one of the first manifestations of SLE, particularly when nephrotic syndrome occurs. Paediatricians, rheumatologists and nephrologists should be aware of this fact. Prompt diagnosis, and rapid and effective treatment are essential for patient prognosis.

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18 June 2010

Dear Editor,

AORTIC COARCTATION AND TWIN PREGNANCY

The occurrence of aortic coarctation in monochorionic twins reported by Van den Boom and co-workers, and its association with twin–twin transfusion syndrome is of great interest.[1] Coarctation of the aorta is a very rare cause of hypertension in adults. We have encountered only two cases diagnosed *de novo* in our hypertension clinic over 33 years, where we see six to seven new patients per week. One of these was a monochorionic twin who also had congenital deafness. She was a 28-year-old patient who was referred to us following a successful pregnancy complicated by mild chronic hypertension with superimposed pre-eclampsia. We found a blood pressure of 150/108 mmHg, and there was marked radio-femoral delay. The blood pressure in her legs was 115/103 mmHg. Chest X-ray revealed posterior rib notching, and echocardiography and angiography confirmed the diagnosis of coarctation with no other cardiac anomalies.[2] She was successfully treated by percutaneous balloon dilatation.[3] We reviewed her twin sister who was normotensive and entirely healthy. There were no cardiac murmurs. Her leg blood pressure was slightly higher than in the arms. Unfortunately, neither sister was able to provide us with information on birthweight. We can therefore only speculate whether there had been twin–twin transfusion syndrome. We have not been able to locate any other reports of coarctation of the aorta and twin pregnancy in adult clinical practice.

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Dear Editor,

HYPERNATRAEMIA IN A NEWBORN BECAUSE OF SALTING OF THE SKIN

Hypernatraemia is rarely encountered in newborns with normal gestational age because their kidneys have the capability of

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