brought to the Department of Pediatrics (in KFH- Al Baha or Al Nour Hospital – Makkah) and subjected to: a detailed history, physical & systemic examinations. Also more urinary, blood and ultrasound studies were done.

Results In **Makkah region** 1st screening shows that prevalence of hematuria was 0.7% & 0.8%, became by 2nd screening 0.1% & 0.1% in male and female, respectively, for proteinuria prevalence by 1st screening was 1% & 0.8% became by 2nd screening 0.1% & 0.2% in male & female respectively. The prevalence of hypercalciuria by 2nd screening was 0.1% & 0.1% in male and female respectively, none of hematuria cases were hypercalciuric.

In **Al Baha region** prevalence of hematuria by 1st screening was 0.7% & 0.8%, became by 2nd screening 0.1% & 0.2% in male & female, respectively, for proteinuria prevalence by 1st screening was 0.7% & 0.8% became by 2nd screening 0.2% & 0.2% in male and female respectively. The prevalence of hypercalciuria by 2nd screening 0.2% & 0.2% in male & female respectively, and 67.6% of male hematuria cases, and 71.5% of female hematuria cases have hypercalciuria.

Conclusion Urinary screening would therefore not only help in early detection but also in the prevention of the deterioration of renal function later in life.

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PSEUDOHYPOALDOSTERONISM SECONDARY TO URINARY TRACT INFECTION IN INFANTS

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Hyponatremia with hyperkalemia in infancy is a rare but life-threatening condition. In the first weeks of life, this scenario is usually associated with aldosterone deficiency due to congenital adrenal hyperplasia (CAH). Pseudohypoaldosteronism (PHA) should be considered in the differential diagnosis of CAH in infants with hyperkalemia, hyponatremia and metabolic acidosis. Urinary tract infections and/or urinary tract anomalies are the most common causes of type 1 secondary (transient) PHA. Adequate replacement with intravenous saline and antibiotic therapy is necessary to correct electrolyte levels and metabolic acidosis within 24–48 hours. Recognition of type 1 secondary PHA enables appropriate management, thus avoiding unnecessary investigations and treatment. Here, we presented five children that emphasized the clinical and biochemical properties of type 1 secondary PHA.

In this study, four male and one female patients whose ages vary between 20 days and 6 months were observed. The mean values of sodium, potassium and bicarbonate were found as 120 ± 8.9 mmol/l, 7.18 ± 0.98 mmol/l, 13.9 ± 6.19 , respectively for five patients. Renin and aldosterone levels were high in all patients. All patients had urinary tract infection with different urinary tract anomalies. These anomalies were unilateral ureterovesical junction (UVJ) obstruction in two patients, bilateral vesicoureteral reflux (VUR) with posterior urethral valve (PUV) in one patient, PUV with bilateral UVJ obstruction in one patient, and unilateral VUR in one patient. The electrolyte imbalance and metabolic acidosis improved after treatment with intravenous saline and appropriate antibiotic agents. Also, renin and aldosterone levels were decreased to normal limits after the aforementioned treatments.

In this study, our aim was to increase awareness for type 1 secondary PHA among pediatricians. Type 1 secondary PHA should be considered in the presence of hyponatremia, hyperkalemia and metabolic acidosis in infants with urinary tract infections and/or urinary tract anomalies. Also, electrolyte and blood gas monitoring should be done in infants with urinary tract infections.

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NOCTURNAL ENURESIS IN CHILDREN: MEDICAL COMORBIDITIES

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Objective To evaluate the characteristics of patients with NE.

Design It is a cross-sectional study.

Setting During the physical examination, we sought signs and symptoms of voiding disorders and comorbidities with precise questions posed to the patients and their parents. Further, we assessed family history and behavioral characteristics of patients. Analyses were conducted using the Microsoft Excel 2016 program. We used descriptive statistics to describe patients' information.

Patients We recruited 403 children with Nocturnal Enuresis (NE) at the Services of Pediatrics, Campus Bio-Medico University Hospital of Rome between June 2013 and July 2018. We rejected 2 children respectively with a renal agenesis and a chromosomopathy and we enrolled 401 patients, 101 girls (25.2%) and 300 boys (74.8%), aged 5–16 years; mean age at first visit 8.8 ± 2.44 years. Of the 401 eligible patients, we counted 327 (81.5%) patients with monosymptomatic NE (MNE) and 74 (18.5%) patients with non-monosymptomatic MNE (N-MNE). In the group of MNE children, 242 (74%) children were boys with mean age at first examination 9.1 years and 85 (26%) were girls with mean age at first examination 7.8 years. In the group of N-MNE children, 58 (78.4%) children were boys with mean age at first examination 9 years and 16 (21.6%) were girls with mean age at first examination 8.4 years. Among the children with MNE, 322 (98.5%) had PMNE and 5 (1.5%) were diagnosed with SMNE.

Interventions Not applicable

Main outcome measures Signs and symptoms of voiding disorders, comorbidities, family history of NE, behavioral characteristics and school achievement.

Results We noticed that heredity, parasomnias, urogenital abnormalities, constipation and innocence heart murmur are correlated to NE. Notably, 53.6% (67/125 children) had paternal heredity, 46.4% (58/125) had maternal heredity; 11.2% (14/125) had both paternal and maternal inheritance. 12/401 (3%) had sleep apnea, 95/401 (23.7%) had somniloquy and 59/401 (14.7%) had bruxism. Children suffered from headaches were 21/401 (5.2%): 112 (27.3%) had family history of headache. 47/300 boys (15.7%) had urogenital-abnormalities: 28/47 (59.6%) children had balanopreputial adhesions. Cutaneous manifestations of spinal dysraphism such as pilonidal dimple, single and deflected intergluteal cleft or double intergluteal cleft were found in 21/401 (5.2%) patients. Encopresis