that vaccination may represent a useful strategy for disease prevention or modulation.[6] Antibodies against oxidized LDL have been demonstrated in atherosclerosis, which may be protective.[7] Serum anti-oxidized LDL antibody titer is an independent predictor of cardiovascular mortality in a cohort of patients with end-stage renal disease.[7] In another study revealed that because antibodies may protect or neutralize pathogens and immunogens, humoral immunity to oxidized LDL can reduce the incidence of atherosclerosis. The protective role of T-cell–dependent antibody was demonstrated in rabbits and mice immunized with oxidized LDL.[8]

In conclusion, immunosuppression in transplantation may cause deficient atheroprotective cellular and humoral immune reactivity. Nontraditional markers add a lot to explain the increased rate of cardiovascular disease in transplantation, especially effects by immunosuppression and renal transplantation. Accelerated atherosclerosis in transplantation probably due to both destructive immunologic forces, inflammatory activity, and adversely affected protective immunologic mechanisms targeting atheroantigens.

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Re: Elevated Serum Levels of Vitamin D in Infants With Urolithiasis

Dear Editor,

We have read with great interest a recently article by Fallahzadeh and colleagues[1] titled "Elevated serum levels of vitamin D in infants with urolithiasis" published in your most valuable journal. They focused on the role of the serum levels of vitamin D on the pathogenesis of urolithiasis in infants. The authors concluded that high serum levels of vitamin D may play an important role in the pathogenesis of renal stone formation, particularly in the infants with hypercalcemia.

Although hyperuricosuria and hyperoxaluria are two important metabolic risk factors in urolithiasis among pediatric patients,[2] it is of interest that Fallahzadeh and colleagues[1] reported hyperoxaluria to be as low as 3% of their patients and they had no hyperuricosuria. However, hyperuricosuria has been reported in 2% to 10% of children and adolescents with metabolic predisposition to renal stone formation.[2]

Urinary stone is related with many complicated factors such as metabolic defects, genetic and environmental effects.[3,4] Fallahzadeh and coworkers showed that 53% of their cases had at least one metabolic disorder.[1] It is of interest that serum levels of 25-hydroxyvitamin D3 were also significantly

greater in patients with urolithiasis than those who had no renal stone.[1] The role of vitamin D receptor (*VDR*) gene polymorphism in pediatric urolithiasis has been shown in several studies.[5,6] Yiwei Lin and associates reported that *VDR* polymorphisms could be potential biomarkers for urolithiasis susceptibility.[7] Ozkaya and colleagues showed an association of *VDR* gene polymorphism with the risk of calcium urolithiasis.[5]

Mortazavi and Mahbubi demonstrated that 60% of patients with renal calculi were under two years of age and 60% of them had history of high dose vitamin D3 injection for suspected rickets.[8] Although it is retrospectively difficult to establish the diagnosis of vitamin D3 overdose when plasma calcium has returned to normal range, this chance should be considered.[8]

We agree that gender has no impact on development of renal calculi in infants (P = .62),[1] which is resemble to our previous study (P = .24).[2] Fallahzadeh et al[1] reported a high family history of urolithiasis (81%), we also found a positive family history of %95 in the first- or second-degree relatives of the infants with renal stone.[2]

Although urolithiasis in children is a relatively infrequent problem,[2] its true incidence in childhood may be higher than prior observations. Some studies demonstrate that the frequency of pediatric urolithiasis has been increased, even in non endemic areas for urinary stone disease.[9,10] This may be partly due to improved alertness and routine practical ultrasonography in children with presenting calculus or non-calculus symptoms for urolithiasis.[2]

We completely agree that evaluating of serum vitamin D in children with urinary calculi. Finally, we suggest that further studies require about supplemental therapy with vitamin D in infants, especially in those who have positive family history of renal calculi.

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Re: Maternal Urinary Tract Infection as a Risk Factor For Neonatal Urinary Tract Infection

Dear Editor,

We read with interest the article recently published in the *Iranian Journal of Kidney Diseases*, titled "Maternal urinary tract infection as a risk factor for neonatal urinary tract infection" by Emamghorashi and colleagues.[1] This case-control study focused on the impact of maternal urinary tract infection (UTI) during pregnancy on the development of neonatal UTI. They showed that maternal UTI can be a risk factor for neonatal UTI and a significant correlation was seen between maternal and neonatal UTI.