

of 150ml/k, a protein binding rate between 50 and 80% (which decreases when levels are high), and a molecular weight of 138.<sup>3</sup> These properties favour its elimination by haemodialysis, which is the indicated treatment in serious cases.

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## Candida-induced recurrent peritonitis after peritoneal catheter reinsertion

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**Dear Editor,**

Peritonitis caused by *Candida* is a rare but serious complication in patients on

peritoneal dialysis, requiring the removal of the catheter in the majority of cases.

We present a case of relapsing peritonitis caused by *Candida parapsilopsis* after a prolonged period of peritoneal rest with adequate antibiotic coverage.

The patient is a 75 year old male with a past medical history of atrial fibrillation and chronic kidney failure (unknown aetiology) that began Kidney Replacement Therapy in November of 2003 with automated peritoneal dialysis.

This treatment was complicated by two episodes of peritonitis: the first episode, in December of 2005 caused by *Staphylococcus epidermidis*, and the second episode in July 2007 by *Klebsiella pneumoniae*, both resolved with antibiotic treatment given according to protocol. Antifungal prophylaxis was carried out in both cases with oral fluconazole.

In December 2007 he sought healthcare for abdominal discomfort, presenting cloudy peritoneal fluid, for which antibiotic treatment was prescribed. A yeast was identified in the peritoneal fluid 48 hours later, and antibiotic treatment with fluconazole and fluorocytosine was initiated. The peritoneal catheter was removed 24 hours after the diagnosis without complications. The patient replacement therapy was changed to haemodialysis, while continuing antibiotic treatment with fluconazole during three weeks.

After eight weeks of treatment and at the patient's request, a decision was made to re-insert a new peritoneal dialysis catheter, after performing an abdominal Computerised Axial Tomography (CAT), where no abnormalities were found except for a great amount of atheromatosis. The implantation of the catheter was performed by a surgeon that ruled out the existence of scar tissue.

15 days after the implantation, peritoneal dialysis treatment was started uneventfully. However after 10 days the patient presented with abdominal pain and cloudy fluid. Microbiology confirmed the new existence of *Candida parapsilopsis* in the peritoneal fluid, for which the catheter was removed and the patient was transferred permanently to Haemodialysis.

Fungal peritonitis in peritoneal dialysis is associated with a high percentage of failure.<sup>1</sup> The majority of the episodes are caused by *Candida species*, the optimal treatment remains unclear, but it requires the abandonment of the PD technique in the majority of cases.<sup>2</sup> Antifungal agents are recommended during a period of no less than 10 days after the removal of the catheter. The optimal time for the reinsertion of a new catheter after a fungal peritonitis is not clearly established. A period of at least 2-3 weeks is recommended.<sup>3</sup> These measures were not sufficient in our case. It may be that a longer period of antifungal treatment or a previous preventive treatment would be indicated in these cases prior to the insertion of a new catheter.

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