Valganciclovir Ganciclovir Prophylaxis. J Med Virol 2005;77:425-9.
4. Cervera C, Pineda M, Linares L, Marcos MA, Antón A, Cofán F, et al. Impact of valganciclovir prophylaxis on the development of severe late-cytomegalovirus disease in high-risk solid organ transplant recipients. Transplant Proc 2007;39(7):2228-30.
5. Asberga A, Humar A, Rollagc H, Jardined AG, Mouase H, Pescovitz MD, et al. on behalf of the VICTOR Study Group. Oral Valganciclovir Is Noninferior to Intravenous Ganciclovir for the Treatment of Cytomegalovirus Disease in Solid Organ Transplant Recipients. American Journal of Transplantation 2007;7:2106-13.

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Cefepime-induced encephalopathy in patients with renal failure

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Dear Editor,

Cefepime is a fourth-generation cephalosporin that is widely used in hospital settings.[1] Since its approval, isolated cases of encephalopathy have been reported in patients with both normal[2] and impaired kidney function.[3,4] Nonetheless, the information about the clinical manifestations and the prognosis of this adverse reaction is scarce. Therefore, we believe it is important to report seven cases of cefepime-induced encephalopathy in patients with kidney failure. These cases corresponded to 4 males and 3 females with an average age of 63 years. All of the patients had acute or chronic renal failure when cefepime was prescribed. The average value of creatinine at the beginning of treatment was 3.6mg/dl and the initial dose of cefepime was 2.75g/day; in five patients the dose was adjusted for the degree of kidney function. The average time period between beginning of treatment and symptoms was 5.4 days. The most common clinical manifestations were a decreased level of consciousness (71.4%) and myoclonus (71.4%). The EEG was pathological in the six cases where it was carried out, demonstrating a non-convulsive epileptic status in three, slowed global activity with repetitive paroxysm in two, and diffuse affectation with a predominance of triphasic waves in one. The CT scan and the spinal tap were normal in all cases. After diagnosing the encephalopathy, treatment with cefepime was discontinued. Three of the patients received dialysis. Three patients improved (42.9%), one of whom required haemodialysis. The 4 remaining patients (57.1%) died from the encephalopathy.

The use of cefepime in patients with kidney failure, even at adjusted doses, may cause serious encephalopathy, and thus its administration should be avoided or used with close monitoring. The appearance of alterations in the level of consciousness and the myoclonus should alert us to the appearance of a non-convulsive status that requires an EEG as it is the most useful diagnostic test. Haemodialysis does not seem to modify the clinical outcome.

1. Sánchez-Bailén MJ, Navarro Ciruelos N, Rovira García-Marrón R, Anglés Coll. Encefalopatía asociada a la administración de cefepime en una paciente con shock séptico e insuficiencia renal. Rev Clin Esp 2004;204(9):501-4.
2. Maganti R, Jolin D, Rishi D, Biswas A. Non-convulsive status epilecticus due to cefepime in a patient with normal renal function. Epilepsy&Behavior 2006;8:312-4.
3. Chatelier D, Jourdan M, Mangalaboyi J. et al. Cefepime-induced neurotoxicity: an underestimated complication of antibiotherapy in patients with acute renal failure. Intensive Care Med 2002;28:214-7.
4. Barbey F, Bugnon D, Wauters JP. Neurotoxicity of Cefepime in Uremic Patients. Ann Intern Med 2001;135:1011.

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Ileal intussusception by carcinoid tumour in patients with chronic renal failure

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Dear Editor,

In connection with the clinical case presented in number 4, volume 26, of this same journal, we would like to report a similar case of intussusception of the terminal ileum by a carcinoid tumour in a patient with chronic kidney failure as it is an infrequent and little referenced illness in patients with chronic kidney failure.[1]

A 54 year old female patient with a history of chronic renal failure, hyperuricaemia and nephrolithiasis. She attended Accident and Emergency with generalized abdominal pain, nausea, vomiting and diarrhoea of 48 hour duration.

She had distended and tympanic abdomen with diffuse pain and no signs of peritonism.

Air-fluid levels could be seen in the small intestine on plain abdominal x-ray. The CT of the abdomen showed a dilated jejunum-ileum with thickening of the terminal ileum and caecum wall and a 4cm mass.

With the impression of an acute intestinal obstruction, the patient underwent urgent laparotomy. The small intestine was dilated to the terminal ileum where a tumour measuring 5cm was found that had caused the intussusception of the small intestine and the obstruction. A right colectomy and an ileum-colonic anastomosis were performed.

The postoperative evolution was satisfactory. A carcinoid tumour of the ileum measuring 1.8 x 1.5cm was