Despite having preserved kidney function, there were no complications due to the CVVHDF technique (Table 1).

As can be seen in the table, therapeutic levels of valproate were reached after 48 hours CVVHDF. More than 99% of drug was removed from serum levels after 5 days thanks to the treatment given, which included continuous kidney clearance (Figure 1).

On the third day of admission there were clinical, analytical and radiological alterations indicative of the existence of nosocomial pneumonia. *Staphylococcus simulans* and *Staphylococcus aureus* were isolated from bronchial secretions, so antibiotic therapy with levofloxacin was initiated. After 4 days of treatment and haemodynamic and metabolic stability, she was transferred to the internal medicine service, with psychiatry support. She was discharged from the internal medicine service on 15 December 2008.

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Fulminant sclerosing peritonitis: dramatic response to steroid treatment

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Dear Editor,

Encapsulating peritoneal sclerosis is a rare complication of peritoneal dialysis (PD). One of its variants, fulminant sclerosing peritonitis (FSP), evolves in a hyperacute form after an episode of bacterial peritonitis. It is a clinical profile regarded with a high index of suspicion and early initiation of steroid treatment, which usually gives a positive, quick and dramatic response. We describe 5 FSP cases with significant clinical improvement after steroid therapy.

We reviewed the medical records of 164 patients receiving PD in Neuquén, Argentina, between 1996 and 2008. Nine of them had symptoms compatible with encapsulating peritoneal sclerosis (5.38%), five of whom corresponded to the variant EPS. Four were women, with an average age of 40 years, PET average low, average high or high; time on PD 3-7 years, 2 patients with a previous history of peritonitis. All had episodes of peritonitis to common germs immediately before the reference symptoms, which is usually characterised by severe impairment, bloating, abdominal pain, fever, diarrhoea, intestinal hypomotility and vomiting. Complementary studies (CT): variable peritoneal thickening, adhesions, calcium deposits, loculations, fibrous tracts, blurring of fat. Some were normal.

Initial therapy: ATB according to sensitivity, catheter extraction, laparotomy and extensive washing.

Evolution: severely affected, systemic inflammatory response syndrome (SIRS) without response to treatment. One patient developed distributive shock and required mechanical ventilation.

Peritoneal biopsies (3 cases): variable peritoneal thickening, hyalinosis, calcifications, necrosis, abscesses, fibrosis, inflammatory infiltrates, consistent with sclerosing peritonitis.

Prednisolone was given to all patients p.o. 1mg/kg/day or IV methylprednisolone pulses, with immediate noticeable improvement in the clinical profile. One patient had gastrointestinal bleeding, was changed to sirolimus and died from hospital pneumonia after the abdominal profile was resolved.

Encapsulating peritoneal sclerosis is a serious complication of PD. Early reports considered it lethal.[1] The prevalence varies according to different authors, from 0.7% increasing during treatment to reach 19.4% in those with more than 8 years.[2] Among the risk factors are the following: time on PD,[2] severe peritonitis, and especially infection by *Staphylococcus aureus*, fungi and *Pseudomonas*, the number and severity of each episode[3-5] and solutions with a high glucose content. A large percentage of cases developed slowly after stopping PD and transferring to HD.[4] In other cases, a continuation of severe bacterial peritonitis followed, as a second phase phenomenon, and acquired the features of fulminant sclerosing peritonitis.[6]

The term sclerosing peritonitis is used to demonstrate the infectious component/acute inflammation shown, and the expression encapsulating peritoneal sclerosis to describe a slow and progressive form of the disease.

We used immunosuppressive treatment in 5 patients with FSP, with a dramatic remission in the symptoms and normalisation of the intestinal transit in less than 72 h. There was only one death, after resolution of the abdominal profile, due to lung intercurrences.

Treatment lasted for 6 months, in decreasing doses until reaching 20mg/day of prednisolone. It was subsequently suspended, without recurrence of the clinical profile. The

patients are still alive, with a follow-up between 2 and 6 years in haemodialysis, and one patient has undergone transplantation.

We conclude that patients with an apparent diagnosis of sepsis associated with primary peritonitis in PD, abdominal signs without remission and negative cultures, must have FSP considered as a diagnosis and early initiation of steroid treatment evaluated. This may save the life of a patient.

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Aortic coarctation as a rare cause of hypertension in the elderly

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Dear Editor,
Hypertension in the elderly is mainly essential with coarctation of the aorta a secondary cause.[1] The median survival of patients with coarctation of the aorta is low: only 25% live past 50 years of age.[2,3] Most cases are women, due to a lower tendency to develop atherosclerosis and hypertension.[4]

Below is the case of a male patient aged 83 who was admitted for surgery of the left paranasal squamous cell carcinoma, which appeared as a complication in a compressive cervical haematoma that required urgent tracheotomy. His background revealed longstanding refractory hypertension. A physical examination revealed a normal cardiopulmonary auscultation with distal pulses present on the upper limbs and diminished in the lower. Blood pressure in the upper right extremity was 182/81mmHg, significantly higher than the left side, where it was 130/75mmHg. The latter was similar to those of the lower extremities. Analytically, the data showed no renal secondary hypertension, thyroid or kidney disease. The echocardiogram revealed a significant hypertrophy of the left ventricle in septal location. A slight cardiomegaly and the inverted E sign (Figure 1) were observed on the radiograph which, together with the difference in blood pressure in both upper extremities, directed us towards a diagnosis of probable aortic coarctation.

Therefore, a chest CT was performed with contrast. This revealed, in the aortic arch, distal to the supra-aortic trunks, a poststenotic dilatation of a maximum of 3.7cm in diameter, compatible with aortic coarctation (Figure 2).

After assessing the clinical status, the tumour staging (T2, N2b, M0) and the high comorbidity of surgery, conservative treatment was chosen.

In conclusion, the diagnosis of aortic coarctation should always be discarded for any patient with refractory hypertension. A proper physical examination with palpation of distal pulses and measurement of blood pressure control between extremities is a good guide towards diagnosis.

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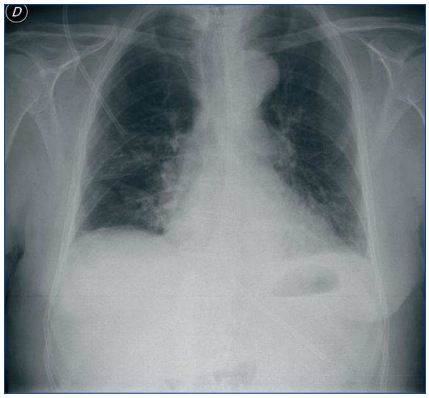

Figure 1. Chest Radiograph.

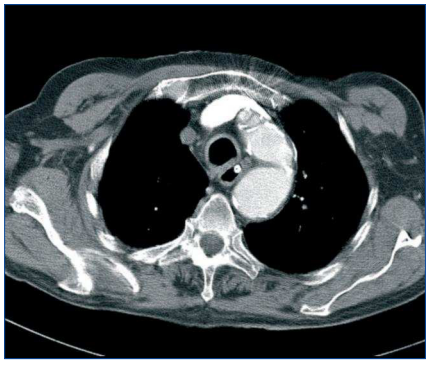

Figure 2. Thoracic CT.