Peritonitis in patients with end-stage renal disease on continuous ambulatory peritoneal dialysis

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To the Editor: We investigated the experiences with continuous ambulatory peritoneal dialysis (CAPD)-related peritonitis in patients with end-stage renal disease (ESRD) at the nephrology unit of Dr George Mukhari Hospital. In this study population, the mortality rate from peritonitis is high, Gram-negative sepsis predominates and the recurrence rate was also high. Age is a risk factor for mortality.

Background

CAPD is an established therapy for ESRD. No costly equipment is required, the technique is easily learned by patients, and frequent hospital visits are not necessary. CAPD does not immobilise patients for prolonged periods of time, requires less rigid fluid and dietary restrictions, and tends to preserve residual renal function longer than haemodialysis. Therefore, CAPD is an important option for treatment of ESRD in developing countries.

A study from Groote Schuur Hospital, Cape Town, found peritonitis to be the major limiting factor for CAPD. Increased frequency of peritonitis was associated with poor socioeconomic conditions, age and diabetes. In contrast, peritonitis rates among patients at Chris Hani Baragwanath Hospital in Soweto were similar to those of the developed world. Socioeconomic factors did not appear to play a role in peritonitis rates or CAPD failure.

The nephrology unit at Dr George Mukhari Hospital has experienced increased pressure on the limited number of haemodialysis ‘slots’ as a result of decreases in live donor transplants and the utilisation of cadaveric donors because of the HIV/AIDS epidemic. This has resulted in an expansion of the CAPD programme.

Despite increased experience and advances in peritoneal dialysis, peritonitis remains a major cause of morbidity in patients on long-term CAPD and is the major cause of treatment failure and the need to transfer to haemodialysis.

Methods and study design

Thirty-one patients with ESRD on CAPD, who had peritonitis between March 2004 and March 2006, were included. The demographic data, primary renal disease, date of Tenckhoff catheter insertion, date of commencing renal replacement therapy, peritoneal infection, biochemistry and microbiology of peritoneal fluid, antimicrobial agents used, mortality rates and the glomerular filtration rate were recorded in each case.

Results

A total of 40 patients with ESRD on CAPD were admitted for peritonitis. Thirty-one files were available for evaluation. Females comprised 68% of the patients; the mean age was 41±22 years, and the mean number of years subsequent to catheter insertion before the development of infection was 1.5±3.1 years. Hypertension was the leading cause of renal disease in 21 patients (68%); adult polycystic kidney disease in 4 (13%); chronic glomerulonephritis and chronic pyelonephritis in 2 each (6.5% each); and nephrotic syndrome and unknown in 1 (3%) each.

Sixty-five episodes of peritonitis were recorded between March 2004 and March 2006. Twenty-one (68%) patients had from 2 to 5 episodes of peritonitis during this period. Seven patients (27%) had 1 episode, 14 (45%) had 2 episodes, and 10 (32%) had >3 episodes.

All 31 patients presented with abdominal pain; 52% were pyrexial; vomiting occurred in 6 (19%); 84% presented with a cloudy dialysate fluid; and in 2, the dialysate fluid was cloudy and had strands. In 3 patients, the dialysate fluid was reported to be clear.

Most of the episodes (65%) were culture-negative. Klebsiella pneumoniae was found in 16%, Gram-positive cocci in 10%, other Gram-negative pathogens in 6%, and Candida albicans in 3%.
The mean peritoneal fluid polymorphonuclear cell count was 270±756/µl, and the mean fluid lymphocyte count 240±409 per µl. All patients under review had an HIV test, and only 1 (3%) was positive.

Ten patients (32%) died during the study period (Table I); their age was 47±6.3 years, which was significantly higher than that of the survivors (36±10.9) (p=0.0236). Patients who died had an average of 2.4 episodes of peritonitis, which was not significantly different from those who survived (p=0.2701). The male and female mortality rates were similar (5/10 v. 5/21, p=0.2220).

Three patients (10%) were transferred to haemodialysis owing to multiple episodes (4 on average) of peritonitis and intra-abdominal sepsis. One of these 3 patients died. The remaining 2 patients continued with haemodialysis.

Serum creatinine ranged from 326 to 1 775 µmol/1 (mean 1 071) and urea from 8.1 to 40.8 mmol/1 (mean 22) on admission to the programme. High values predict poor outcome. Serum albumin concentration ranged from 3.9 to 84.8×10\(^4\) (mean 61). Patients with normal values had a good outcome. Haemoglobin ranged from 7.2 g/l to 14 g/dl (mean 9.5). White cell counts ranged from 3.9 to 84.8×10\(^4\) (mean 12.2); patients with chronic myeloid leukaemia, who both died, had the two highest counts.

**Discussion**

Abdominal pain (the most common presenting symptom in our study) was found to be a reliable sign of peritonitis in most other studies.\(^8,9,11,18\) The high number of Gram-negative pathogens in our study contrasts with others that reported multiple episodes occurred in 18 - 35%.\(^8,9,18\) Katz et al. reported that black patients tended to have high recurrence rates.\(^7\) Blacks have been shown to have an increased risk of developing peritonitis compared with whites, even after adjusting for socioeconomic and co-morbid factors.\(^9\)

Only 2 patients in our study had their dialysis catheter removed because of intra-abdominal sepsis. One of these patients had peritonitis due to *C. albicans* and was treated with intravenous fluconazole and the dialysis catheter removed as part of the standard protocol. Fungal peritonitis is an uncommon but potentially life-threatening complication of CAPD, with a reported incidence of fungal peritonitis of 3 - 6%.\(^8\)

**Conclusion**

Our study confirms that CAPD is a useful and practical alternative to haemodialysis in our setting. However, CAPD-related peritonitis remains a major threat and carries a high mortality rate, especially in older patients. Our findings suggest that catheter insertion should be performed by trained dialysis unit staff; patients should be educated to present to the unit if they experience any abdominal pain; peritoneal dialysate fluid should be inoculated directly into blood culture bottles; and patients should be told to avoid antibiotics unless prescribed by dialysis unit staff.

**References**


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