anti-histone antibodies remained detectable for >9 months after drug withdrawal. The experience with the present patient and the information in the literature lead us to the notion that when we meet HD patients with de novo lupus-like syndromes, we should suspect ticlopidine and other drugs, even those that patients have been using for years. In such circumstances, the detection of anti-histone antibodies seems useful for diagnosing drug-induced lupus, but their titres are unlikely to parallel clinical improvement.

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Percutaneous removal of a right atrial catheter fragment: the value of the En Snare

Sir,

We are writing to you about a case that raises a number of points we feel would be of interest to your readership.

A 36-year-old female patient on chronic haemodialysis treatment was referred to the interventional radiology department for assessment of a non-functional twin tunneled Bioflex catheter (Medcomp, Harleysville, PA). The lines had been placed without the aid of fluoroscopy ~11 months previously. Post-procedural radiography had demonstrated the tips of the lines to lie in the right ventricle and right atrium, respectively. Due to significant patient co-morbidity, the lines were not exchanged and functioned well for 11 months.

Fluoroscopy revealed that one line tip remained against the wall of the right ventricle and that the end of the second line had fractured ~2.5 cm from its tip, with the fractured portion lodged in the right atrium wall. The precise time of catheter fracture could not be determined as the last radiograph prior to malfunction was 5 months previously. This had demonstrated the tip of the proximal line curled against the right atrial wall and we postulate that repetitive stress with atrial systole led to the catheter fracture at the apex of the curl. As the fragment could be embedded in the right atrial wall, trans-oesophageal echo was performed prior to attempted fragment retrieval. This showed a small volume of thrombus in the superior aspect of the right atrium near the superior vena cava which was separate from the line fragment lying at the junction of the lateral atrial wall and tricuspid valve.

Accordingly the patient was heparinized and scheduled for percutaneous removal of the catheter fragment in the interventional radiology department. This has now become the primary method of removal in most scenarios [1,2]. In recent years, single loop snares such as the nitinol gooseneck snare (Microvena, White Bear Lake, MN) have been used with great success. In this case, following failure to grasp the fragment with gooseneck snares, we used a new type of snare, the En Snare (Medtech, FL), which immediately grasped the catheter fragment. This snare system has three interlaced loops rather than the traditional single loop, and the speed with which the catheter fragment was captured would suggest that this design offered a particular advantage in this case (Figure 1).

We feel that the curling of the catheter line against the wall of the right atrium was a contributing factor to the line fracture and, if this appearance was seen again on chest radiograph, we would advise withdrawal or exchange of the catheter. This case also highlights the importance of trans-oesophageal echo when the timing of line fracture is uncertain and also the usefulness of the new En Snare system in these types of cases.

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A case of invasive pulmonary aspergillosis in renal failure

Sir,
A 55-year-old ex-community care assistant was admitted with a 2 day history of increasing shortness of breath and productive cough. She suffered with chronic kidney impairment secondary to reflux nephropathy, and had undergone a nephrectomy 1 year previously. After gradually worsening uraemic symptoms, a peritoneal dialysis catheter had been inserted uneventfully 1 month prior to her admission. She was due to start training for peritoneal dialysis within the next few days (GFR 7 ml/min, serum urea 32 mmol/l, creatinine 536 μmol/l). An ultrasonogram had showed the remaining kidney to be of normal size, and serum immunoglobulin levels were normal. She was a smoker of 20 cigarettes per day, but there were no medical antecedents of note. Her medications reflected uraemia, and the biochemistry otherwise had been unremarkable.

On admission, she was tachypnoeic (30 respirations per minute) and hypotensive at 108/60 mmHg. The right lung was clear on auscultation, but there was wheeze at the left base. Oxygen saturation on air was 86%, and an arterial blood gas analysis showed profound metabolic acidosis. The chest X-ray was normal, but there was a slight leukocytosis (12.7 x 10^9/l), and the biochemistry showed end-stage renal failure (urea 49 mmol/l, creatinine 1319 μmol/l). She was managed with broad-spectrum antibiotics (intravenous ceftazidime 1 g OD) and haemodialysis via a femoral central catheter. Repeated arterial blood gases showed a normalized pH and base excess, but the hypoxia and clinical air hunger persisted. She was transferred to the High-Dependency Unit, but severe bronchospasms rendered ventilation very difficult. Serial chest X-rays showed rapid development of dense perihilar infiltrates, and sputum cultures from admission grew Aspergillus fumigatus. The chest X-ray showed a raised right hemidiaphragm, and the sputum cultures were consistent with Aspergillus fumigatus. Despite treatment with liposomal amphotericin B from admission day 3, death ensued within hours. The autopsy confirmed extensive Aspergillus infection, coating the tracheobronchial tree and invading bronchial walls and vasculature (Figure 1).

Infections cause considerable morbidity and mortality in chronic kidney failure [1], and mycoses are seen in dialysis-dependency [2], as well as in non-dialysing uraemia [3,4]. Invasive pulmonary aspergillosis is probably the most aggressive fungal infection known to man. It occurs mainly in severely immunocompromised patients, and has not previously been reported in a non-dialysing uraemic patient. Cigarette smoking has been associated with airway colonization by Aspergillus [5], but it unclear whether this predisposes to invasive disease.

The increasing seniority of our uraemic population, as well as their frequently diabetic background [6,7], contribute to further immune dysfunction. This report emphasizes the message that renal physicians should keep a low threshold for diagnosing opportunistic infection in their patients.

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A. Aspergillus fumigatus
B. End-stage renal failure in diabetes type II—a silent epidemic.

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Fig. 1. Histology view of bronchial tree. H/E section view (a) shows carpet of fungal organisms coating luminal surface. Silver stains (b) highlight fungal hyphae of Aspergillus. Scales: larger, 0.4 mm for (a); smaller, 0.1 mm for (b).

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