confirmed by arteriography when two endoprosthesis wallgraft (diameter 12 mm, length 60 mm, Boston Scientific Meditech, Natick, MA, USA) were successfully placed percutaneously in the lumen of both arteries (Figure 1). Additional studies did not reveal any other potential cause of the fever. The patient was haemodialysed and maintained on antibiotic treatment until discharge.

The concomitant presence of peritonitis and bilateral pseudoaneurysms, without any other infectious focus or previous endo-cardiovascular manoeuvres, was suggestive that both processes were associated and that peritonitis was the cause of the mycotic pseudoaneurysms.

A mycotic pseudoaneurysm is defined as a disruption of all layers of the arterial and the surrounding tissues and haematoma providing a temporary seal. In the course of time, a fibrous capsule will be formed that can increase in size because of the pressure of the bloodstream [1].

In the general population, pseudoaneurysms in the aortoiliac area are described as a rare complication of intra-abdominal infectious processes. Also, cases related to arterial stents [2], as a complication of liver transplants [3] or retrograde urinary tract infection in renal transplantation, have been reported [4].

In our case, the origin seems to have been caused by the adjacent peritonitis presented by the patient. However, although peritonitis is common in CAPD patients, until now there has not been any report of the association of peritonitis with iliac pseudoaneurysms in this population.

Diagnosis is based on radiological techniques. The association of a positive haemoculture is found in 50–85% of the cases. A pathogenic agent is isolated in the culture of the aneurismatic tissue in 76% [5,6]. In our patient, there was no possibility of tissue culture as the treatment was carried out with an intra-arterial endoprosthesis. This type of therapy is an emerging alternative as it is efficient and less invasive than the traditional approach. It should not be forgotten that concomitant treatment with adequate antibiotics must also be administered.

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1Departments of Nephrology
2Vascular Radiology and
3Vascular Surgery
Hospital Ramón y Cajal, Madrid
Spain
Email: lianof@yahoo.es

Cristina Galeano1
Fernando Lianío1
María T. Tenorio1
Maite Rivera1
Juan Sánchez2
Jorge Haurie3
Joaquín Ortúñol

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An unusual case of CAPD-related peritonitis associated with fallopian tube capture of a CAPD catheter

Sir,

Peritonitis is the main infectious complication in patients undergoing continuous ambulatory peritoneal dialysis (CAPD). The most common organisms causing bacterial peritonitis are gram-positive, although the number of gram-negative infections is increasing [1]. The connection site or

Fig. 1. Left: arteriography demonstrating bilateral iliac pseudoaneurysm. Right: angiographic control after endoprosthesis deployed.
the pericatheter route are common routes of infections [2].

Here, we report on a patient with a gram-negative CAPD-related peritonitis presumably caused by an ascending infection due to fallopian tube capture of the CAPD catheter.

An 81-year-old woman with coronary heart disease and end-stage renal disease as a consequence of diabetes mellitus underwent an uncomplicated surgical insertion of a Tenckhoff catheter. After 2 weeks, CAPD was started without difficulty. Another 2 weeks later she experienced an acute pain in the middle of the abdomen. The effluents became cloudy and haemorrhagic, and she was admitted to our dialysis centre. On physical examination we saw a non-acutely ill-looking woman with a slightly diffuse tender abdomen. There were no signs of an exit-site infection. Abdominal radiographs showed the catheter positioned in the minor pelvis. The CAPD fluid had an elevated white cell count (WCC) of 4.1 × 10⁶/l. The gram stain was negative and the fluid was inoculated into a blood culture system. (Bactec® BD diagnostics, NJ, USA). The peripheral WCC was 6.6 × 10⁶/l and serum C-reactive protein (CRP) was 192 mg/dl (normal <6 mg/dl). Intrapерitoneal ceftriaxone (2 g/day) was administered, and CAPD was continued. Symptoms rapidly resolved and on day 3, the CRP had declined to 98 mg/dl and leucocyte count in the CAPD fluid to 0.4 × 10⁶/l. In the first CAPD fluid, cultured on admission, an Escherichia coli sensitive to ceftriaxone was identified.

On day 5, the patient died unexpectedly of sudden cardiac death. The post-mortem examination of the peritoneal cavity showed a partial adhesion of the left fallopian tube to the CAPD catheter. The fimbriae were partially haemorrhagic and penetrated the catheter lumen. Histology demonstrated chronic inflammation of the fimbriae. Furthermore, no diverticulitis or organ perforations were seen.

To our best knowledge, this is the first case indicating that entrapment of a CAPD catheter into the fallopian tube and fimbriae is a cause of CAPD-related peritonitis. Fallopian tube wrapping is a rare cause of catheter obstruction [3,4]. However, our patient did not encounter in- or out-flow problems, probably because of residual well-functioning drainage holes.

CAPD peritonitis may occur by several routes. The connection sites, tunnel and exit-site are thought to be the most frequent infection routes [2]. The transluminal route, such as migration across the bowel wall, and the haematogenous route are less frequent. The ascending route, such as migration across the bowel wall, and the most frequent infection routes [2]. The transluminal route via the genitourinary tract seems most likely in this case.

This case demonstrates that although extremely rare, entrapment of a CAPD catheter into a fallopian tube and fimbriae is a possible cause of CAPD-related peritonitis. This underlines the different routes of infection in CAPD-related peritonitis.

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1Department of Internal Medicine University of Witten/Herdecke Germany
2Department of Internal Medicine and Nephrology Academic Hospital Maastricht The Netherlands
3Institute of Pathology University Hospital RWTH Aachen Germany

Email: ulrichgladziwa@gmx.de


Unexpected rate of severe leucopenia with the association of mycophenolate mofetil and valganciclovir in kidney transplant recipients

Sir,

ganciclovir (2 mg/kg 3 times daily) has been used for prevention therapy in 16 kidney transplant recipients. Leucopenia has been reported as a side effect of ganciclovir therapy at a frequency of 10–13% [1,4] but incidence of severe leucopenia was low (4.9%) with no leucopenia-associated sepsis reported [1]. The percentage of patients discontinuing treatment because of leucopenia or neutropenia was not different compared with patients treated with ganciclovir (2 vs 2.4%). Interestingly, when leucopenia occurs, physicians are more likely to taper mycophenolate mofetil (MMF) rather than ganciclovir dose. Nevertheless, as has been clearly proven, any MMF dose reduction increases the risk of acute rejection and graft loss [5].

We present here our experience in using ganciclovir for prevention therapy in 16 kidney transplant recipients. The CMV antibody donor/recipient pattern was D+R− (n = 7), D+/R+ (n = 8), D−/R− (n = 1). Immunosuppressive protocol consisted of anti-interleukin-2 receptor antibodies, prednisone, MMF and cyclosporine. Moreover, all patients were treated with trimethoprim-sulfamethoxazole (TMP), 400 mg per day. Renal function of patients, MMF and ganciclovir doses are summarized in Table 1.

Six patients (37.5%) developed severe leucopenia in the third month of transplantation and met the criteria of agranulocytosis (neutrophil count <500/mm³). Three of them experienced neutropenia-associated sepsis (one diarrhoea secondary to campylobacter jejuni infection, one fever

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Creatinine clearance (ml/min/1.73 m²)</th>
<th>VGC dose (mg/day)</th>
<th>MMF dose (mg/day)</th>
<th>MMF area under concentration curve (mg h/l)</th>
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<td>21.8</td>
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