Unexpected and late diagnosis (28th week) of pregnancy in a 39-year-old patient on chronic haemodialysis

Sir,

Patients undergoing chronic dialysis often believe they are unable to conceive, because of irregular menstrual cycles and decreased libido; consequently, they do not regularly use contraceptive methods. Pregnancy is detected late, particularly in patients on peritoneal dialysis [1]. Early detection of pregnancy in dialysis patients is very important, in order to choose adequate methods for follow-up and treatment; late diagnosis increases the risk of maternal and foetal complications. We present a case of chronic haemodialysis, in which pregnancy was detected in the last trimester of pregnancy.

Case

A 39-year-old patient had been followed at a private dialysis unit for 3 years. She was on dialysis, three 4 h sessions weekly, and she discovered her 28 weeks’ pregnancy only incidentally. She was followed by a gynaecologist after this diagnosis and was admitted to our hospital in the 32nd week, when contractions had begun. Her blood pressure was 140/80 mmHg and there was no physical abnormality, except for bilateral pretibial oedema. Emergency laboratory tests revealed the following results: BUN 213 mg/dl, creatinine 6.5 mg/dl, Na 132 mmol/l, K 4.8 mmol/l, Ca 7.8 mg/dl, haemoglobin 10.7 g/dl. The patient had a vaginal delivery, a male baby of 1600 g weight and Apgar score of 7 (at first minute) and 8 (at fifth minute). The baby was cared for in the newborn unit and the mother continued her dialysis programme with no further problems.

Discussion

Pregnancy and normal labour is a rarely observed condition in end-stage chronic renal failure patients. Recent reports suggest that the pregnancy rate in chronic dialysis patients is 1–7% and 30–50% of these end in normal labour and birth [2,3]. Because of irregular menstruation, even amenorrhoea in chronic renal failure patients and nausea and vomiting, early symptoms of pregnancy, are frequently observed symptoms in this group of patients [4]. Our patients’ menstruation had been irregular for 3 years, and she had not used contraceptive methods; her pregnancy was detected only incidentally in the last trimester. Early diagnosis of pregnancy is very important for maternal and foetal health. Thus, female dialysis patients of reproductive age should either use regular contraception or be regularly controlled for pregnancy if they want to have a baby.

Conflict of interest statement. None declared.

Conflict of interest statement. None declared.


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Use of tunnelled haemodialysis catheters at the start of haemodialysis—success rates and definition of infection

Sir,

With the increasing frailty of established renal failure (ERF) patients, increasing numbers of patients with diabetes, and variable arteriovenous fistula (AVF) success rates, the traditional view that an AVF or graft is best is now being challenged—as a tunnelled line (TL) is a reasonable option. In many studies, the definition of TL infection (TLI) is unclear. We present the results of a retrospective study of 53 consecutive patients, who had a tunnelled line inserted by single operator (VA), in the period June 2004 to July 2005. The aims were to examine: (i) the usefulness of TLs in the first 3 months of haemodialysis; (ii) different definitions (crude, adjusted) of TLI; and (iii) factors affecting infection.

Crude TLI was defined as an episode of fever >38°C not during dialysis, when a blood culture (BC) was taken, with no other obvious source of infection. An adjusted TLI occurred if that BC was positive.

At 3 months, 50 patients were still on haemodialysis (49 with a TL), 2 on peritoneal dialysis, and one had recovered renal function. Blood cultures were taken from 44/53 patients; 11 of the 44 patient episodes were BC-positive. These patients have a mean white count of 11 × 10⁹/l and C-reactive protein (CRP) of 180 mg/dl; one had diabetes. In the 33 BC-negative patients, the white count was 10 and CRP 119, and 9 had diabetes. In other words, if a BC was taken from a patient with diabetes, it was less likely to be positive.

Thus the crude rate of TLI was 9.2 per 1000 patient days; with 83% of whole group having had a TLI by this definition. But the adjusted rate was 2.3 per 1000 patient days (20% patients had a TLI by this definition).

In conclusion, in this study, if on haemodialysis, a TL was still the primary form of access at 3 months, in 98% of patients. Thus, tunnelled lines are a reasonable form of access in frail ERF patients. The rates of crude and adjusted infection were very different, partly due to the adjusted rate ‘missing’ many patients with diabetes. This is a concern, as diabetes is a recognized risk factor for TLI [1]. For this reason, we would propose that the more inclusive crude rate is used to compare one unit to another, with an arbitrary first 3 months of TL being analysed. White count and CRP were unhelpful in distinguishing BC-positive and negative infections.

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