

## A CASE OF ENDOSCOPY-RELATED PERITONITIS IN A PERITONEAL DIALYSIS PATIENT

Minesh Pathak, Tibor Fulop. University of Mississippi Medical Center, Jackson, Mississippi.

We present a case of a 54 year-old female with end-stage renal disease on continuous ambulatory peritoneal dialysis (PD) and history of systemic lupus erythematosus and hypertension. She presented with two days history of generalized abdominal pain, associated with nausea and vomiting. She reported no fever, hematemesis, melena, hematochezia, diarrhea or cloudy PD effluent. Her symptoms started shortly after an upper gastrointestinal (GI) endoscopy with biopsies, revealing only "inflammation and a small hiatal hernia.

Vitals on admission: heart rate of 145/min, blood pressure 135/66 mmHg, respiratory rate 35/min. She was in moderate distress and looked clinically ill. Physical exam revealed moderately diffuse tenderness, lack of bowel sounds and involuntary guarding. Laboratory results: ABG with pH of 7.48, pCO<sub>2</sub> 28 mmHg, PO<sub>2</sub> 85; serum HCO<sub>3</sub> 18 mMol/L, potassium of 7.7 mMol/L, lactic acid 7.2 mMol/L, WBC count 15,100 /mm<sup>3</sup>. Acute peritonitis with sepsis was entertained and surgery was immediately consulted. Subsequent exploratory laparotomy revealed copious murky fluid, without evidence for bowel perforation or obstruction. Peritoneal dialysis (PD) catheter was removed. Peritoneal fluid Gram stain showed both gram positive and gram negative flora. Blood cultures grew *S. pneumoniae*. She received also appropriate treatment with broad antibiotic coverage and hemodialysis was started for renal replacement therapy.

Discussion: Peritonitis occurs commonly in patients undergoing peritoneal dialysis, either due to direct contamination of the fluid bag connector, or due to tunnel infection of PD catheter. This case report likely represented a transmural route of infection resulting from biopsy with upper GI endoscopy. When evaluating patients with PD peritonitis, focused history should specifically query recent GI procedures. Early surgical exploration and broad spectrum coverage, including empiric anaerobic coverage may be appropriate for these patients.