

POS-718 Case of Kocuria spp. induced peritoneal dialysis related peritonitis

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-0.208, $p = 0.015$). Plasma omentin-1 level was significantly associated with the subsequent duration of hospital stay (adjusted relative risk [ARR] 2.91, 95%CI 1.11 to 7.64, $p = 0.032$) and the duration of hospitalization (which is adjusted to the duration of follow up) (ARR= 2.71, 95% CI 1.01 to 7.29, $p = 0.049$).

Conclusions: In new PD patients, plasma omentin-1 level was associated with duration of hospital stay. PDE omentin-1 level correlated with peritoneal transport characteristics. The role of plasma and PDE omentin-1 levels as biomarker for PD patients require further study.

No conflict of interest

POS-718

CASE OF KOCURIA SPP. INDUCED PERITONEAL DIALYSIS RELATED PERITONITIS



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Introduction: Peritonitis is a serious complication of peritoneal dialysis (PD) and is commonly caused by coagulase negative staphylococcal species and staphylococcus aureus. PD related peritonitis contributes to death in up to 8.6% of patients and often results in transition to haemodialysis. In this case we illustrate a rare presentation of Kocuria causing recurrent, treatment resistant peritonitis that resulted in eventual cessation of PD and switch to haemodialysis. Kocuria species are commonly found as skin commensals on human and other mammal skin and rarely cause systemic infections in humans. Despite only 12 case reports of Kocuria induced peritonitis in patients undergoing PD having been reported, Kocuria is increasingly being recognised as an important pathogen in humans.

Methods: We describe an 84 year old woman with end stage renal failure of an unknown aetiology who was commenced on PD in 2016.

Results: The patient was maintained on PD until November 2019 where she was admitted with Acinetobacter induced peritonitis that was treated with oral quinolones. In March 2021 she was admitted again with Kocuria Spp. induced peritonitis where she was treated with intraperitoneal vancomycin and oral ciprofloxacin. Despite displaying adequate sensitivities to these antibiotics, Kocuria Spp. continued to be cultured from her peritoneal fluid. As medical management of her peritonitis failed her PD line was removed in April 2021 and she was commenced on haemodialysis.

Conclusions: This case is a good example of a rare microbe causing PD related peritonitis that, despite displaying wide ranging sensitivities during laboratory testing, was resistant to intraperitoneal antibiotics. This case adds to the growing literature suggesting that Kocuria Spp. are important causative organisms of human disease and should be considered when designing treatment pathways for peritoneal dialysis related peritonitis.

No conflict of interest

POS-719

A NOVEL GUIDE WIRE-FREE TENCKHOFF'S CATHETER INSERTION TECHNIQUE (SAJJA'S TECHNIQUE) FOR INITIATION OF PERITONEAL DIALYSIS: A PROSPECTIVE COHORT



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Introduction: Currently, modified Seldinger's technique (MST) is the standard technique for percutaneous Tenckhoff's catheter (TKC) insertion. However, the use of guide wire in this technique could lead to bowel injury. Herein, we propose a novel guide wire-free TKC insertion technique, so called Sajja's Technique (SJT).

Methods: We prospectively collected data of patients who underwent TKC insertion for the first time between June 2018 and August 2021, by using either MST or SJT. In the SJT (figure 1), paramedian skin incision was made at below umbilicus under local anesthesia. Subcutaneous tissue was dissected, and stab incision was made at anterior rectus sheath and was subsequently dilated with an artery clamp. Then, the posterior rectus sheath was directly penetrated using a dilator with peel-away sheath without use of guide wire or creation of pseudoascites preceding the insertion. TKC was subsequently inserted via the peel-away sheath. Catheter tunnelling using tunnelling device and vertical mattress suture of entry site were similar to the MST. The catheter-related outcomes were compared between those who underwent TKC insertion with MST and SJT.

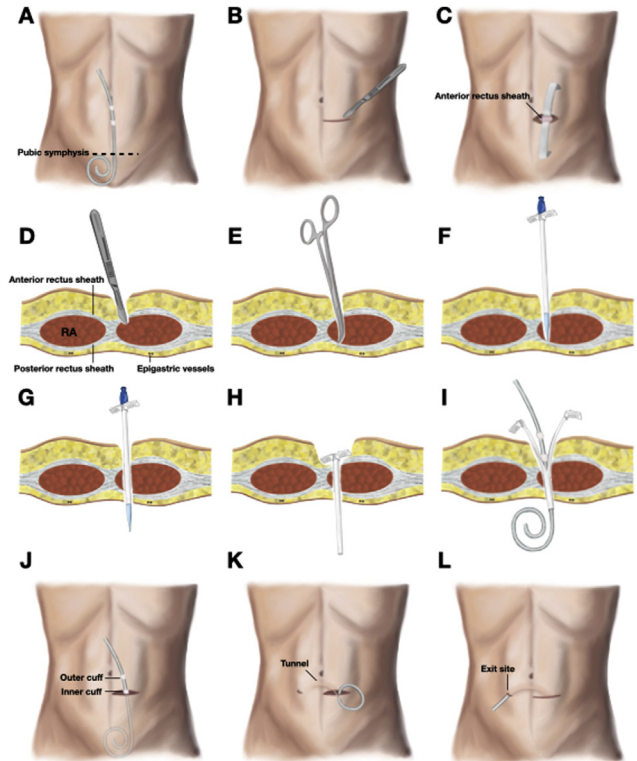


Figure 1 Illustration of Tenckhoff's catheter (TKC) insertion by the Sajja's Technique. Catheter is measured to cover the curled part under pubic symphysis (1A). Paramedian incision is made at between outer and inner cuffs (1B). Subcutaneous fat is dissected to reveal anterior rectus sheath (1C). Stab incision is made at anterior rectus sheath (1D). The stab incision is dilated with curved clamps and dilator with peel-away sheath (1F). Posterior rectus sheath is penetrated using dilator with peel-away sheath (1G). Dilator is removed (1H) and replaced with TKC (1I). Peel-away sheath is removed (1J). TKC tunnel is made with tunnelling device (1K). Entry site is sutured with vertical mattress technique (1L).

Results: 594 patients were enrolled, 62.5% were male. The mean age was 63 ±18 years. 34.4% with diabetes, 75% with end-staged kidney disease, and 11.3% with urgent-start PD. All TKCs were inserted by a nephrology team. The operation time was lower in the SJT ($P=0.01$). The catheter-related outcomes did not differ between the two techniques, including catheter migration, catheter obstruction, peri-catheter leak, exit-site infection, PD-related peritonitis, catheter survival, and technique survival. Hemoperitoneum was lower with the SJT, but bowel injury was comparable between the two techniques. There was one case under MST who developed bladder injury. The SJT was relatively simple to learn. The learning curve is quite short. Untrained physician could master the technique smoothly after only a few sessions of training under supervision. Since SJT requires a relatively less clinical skills, when compared with MST, but with comparable RCOs