

***Burkholderia Cepacia* Peritonitis in Ambulatory Peritoneal Dialysis**

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The Editor

Sir,

I have recently read two interesting articles, by Apostolovic *et al* and Yap *et al*, about infections by *Burkholderia cepacia* (*B cepacia*) in chronic patients undergoing peritoneal dialysis (1, 2).

For the first time in literature, Apostolovic *et al* described the case study of repeated peritonitis by *B cepacia* affecting a patient on continuous ambulatory peritoneal dialysis (1). The authors emphasized the current rarity of this condition in the out-patient environment, and the good outcome of peritonitis in response to antibiotic treatment without catheter removal. Moreover, the article's discussion can enhance the awareness of general practitioners and nephrologists about the possible role of rare, opportunistic agents in chronic renal patients (1).

Yap *et al* reviewed chronic renal patients in peritoneal dialysis, with exit-site infection related or not to tunnel tract or peritoneal involvement by *B cepacia*. Among 22 of the studied individuals, 36.4% and 31.8%, respectively, had immunosuppression and previous skin changes; both tunnel-tract and peritoneal infection occurred in 13.6% of the patients. Antibiotics alone controlled 68.2% of the infections, but 31.8% required catheter removal (2).

Burkholderia cepacia was sensitive to ceftazidime or piperacillin/tazobactam (95.5%) and piperacillin (90.5%), and was resistant to aminoglycosides (80–100%) and ticarcillin/clavulanate (91%). The authors highlighted the high transmissibility and risk of recurrence, the resistance to multiple antibiotics and the need for catheter removal in a third of the reviewed patients (2).

The articles commented on have contributed to enhance the knowledge of healthcare workers pertaining to multidisciplinary dialysis teams about these *B cepacia* infections. Notwithstanding, I would like to add some comments about a Brazilian report focussing on *B cepacia* endocarditis related to an incidentally detected intracardiac fragment of catheter (3).

The patient had chronic renal disease was on haemodialysis eight years before her renal transplant, she had circulatory shock and a central catheter was peripherally inserted. Azathioprine, tacrolimus, and prednisone were employed after transplantation, and she developed endocarditis with *B cepacia* in association with the intracardiac foreign body (3). The catheter fragment was removed by cardiomy, the cultured infectious agent was sensitive to sulfamethoxazole and trimethoprim and the infection was successfully controlled. The authors emphasized the growing number of infections by *B cepacia*, (1–3); and the risk of endocarditis in immunosuppressed people, mainly the group of renal transplant patients (3).

The articles herein commented about conditions scarcely reported which might enhance the suspicion index, which would decrease the number of under-diagnosis and under-reported cases.

Keywords: *Burkholderia cepacia*, endocarditis, peritoneal dialysis, peritonitis

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