Letters to the Editor

Hepatic abscess and cystic fibrosis

Sir,

In a recent issue of the *Journal*¹ we described two male siblings with cystic fibrosis, whose course was complicated by the development of liver abscesses. At the time, the cause of infection in these patients was unclear, as culture of the material aspirated from the liver abscesses was sterile in both cases. Recently, however, one of these patients (Case 2) developed a further, large abscess in the right lobe of the liver. Culture of the material obtained on transcutaneous drainage of this lesion grew *Pseudomonas cepacia*, an organism with which the patient's sputum had been colonized for several years. In view of this, it is likely that this hepatic abscess resulted from metastatic infection from the patient's lower respiratory tract. Immunological studies, including a nitroblue tetrazolium test (NBT), were again entirely normal. The abscess resolved following a 6-week course of parenteral anti-pseudomonal antibiotics.

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Peritoneal dialysis in a patient with haemophilia and chronic renal failure

Sir,

Although haematuria is a common manifestation of haemostatic abnormality in haemophiliacs, chronic renal failure is seen infrequently.¹ The management of the chronic renal failure may require dialysis. The safety of dialysis in patients with congenital haemophilia and uraemic bleeding diathesis is not well known.

A 27 year old man with severe haemophilia (Factor VIII <1%) was found to have renal failure in March 1987, and was admitted with uraemic symptoms in October 1987. An ultrasound examination of the abdomen showed normal sized kidneys. Serology for human immunodeficiency virus (HIV) (Western blot and ELISA) was positive. Haemodialysis was begun through a subclavian Quinton Mahurkar catheter three times a week under factor VIII coverage. Two weeks later, a peritoneal dialysis (PD) catheter was introduced under general anaesthesia. The patient was transfused factor VIII pre- and post-operatively for about a week. Subsequently the patient underwent thrice weekly PD without factor VIII replacement except on two occasions when the peritoneal fluid return was blood tinged. The patient received factor VIII for a pericardial effusion,

haemarthrosis and tonsillar bleed during this period. The PD catheter had to be replaced twice because of blockage, and after four months the patient was maintained on haemodialysis.

The aetiology of renal failure in our patient is unclear. Renal failure with heavy proteinuria and hypertension has been reported in patients with positive HIV serology.² The incidence of hypertension in haemophiliac patients despite renal abnormalities is comparable to that in the general population.¹ There have been three previous reports^{3–5} on the management of chronic renal failure with haemodialysis in patients with haemophilia. They subsequently underwent renal transplantation. Our experience indicates that PD may be relatively safe; these patients do not require routine factor VIII replacement therapy prior to each procedure. PD also excludes the danger of bleeding through a vascular access site. Since a majority of haemophiliacs are serologically positive for HIV, as was our patient, the risk of exposure of medical personnel may be less in a closed system of peritoneal dialysis. The anticipated complications of local haemorrhage or haematoma formation either in the abdominal wall or intraperitoneally are uncommon with the newer sialastic catheters. Optimization of haemostasis prior to catheter placement is appropriate, but routine administration of factor concentrates before each dialysis procedure is not indicated unless bleeding complications are present.

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The drug treatment of asthma

Sir,

I very much enjoyed reading the Festschrift for Professor Margaret Turner-Warwick, *Postgraduate Medical Journal* 1988, Volume 64, Supplement 4. However I did notice that in Dr Hargreave's article, 'The drug treatment of asthma: how can it be better applied?' Dr Hargreave states that 'The