Letters to the Editor

Listeria monocytogenes peritonitis during continuous ambulatory peritoneal dialysis (CAPD)

Sir,

Listeria monocytogenes has become increasingly recognized as an important cause of sepsis during the perinatal period, and also of opportunistic infections in adults. According to Seeliger¹ the usual site of entry in man is the intestine via the oral route. We report here a case of *Listeria* peritonitis in a CAPD patient. Although this species is a recognized cause of sepsis in renal transplant and haemodialysis patients,^{2,3} this is only the second documented case of CAPD peritonitis.

The patient was a 53 year old man with Wegener's granulomatosis and chronic renal failure, receiving treatment with cyclophosphamide (25 mg/day). He had been on CAPD for 6 months when he came to the Renal Dialysis Unit complaining of lower abdominal pain and cloudy bags. His peritoneal dialysis (PD) fluid showed 800 white cells/mm³ with 40% polymorphonuclear leucocytes, 45% mononuclear cells and 15% degenerated cells. Microscopical examination of the dialysis sediment showed no organisms. However, culture of the dialysate fluid in Bactec bottles (Bactec NR 660 system) for 24 hours yielded Gram-positive rods subsequently identified as *Listeria monocytogenes*.

Initially the patient was treated empirically with vancomycin and aztreonam for 48 hours. Although the organism was sensitive to vancomycin the PD fluid remained cloudy and *L. monocytogenes* was again isolated 48 hours after the start of treatment. Therefore, the antibiotics were stopped and treatment with ampicillin 50 mg/l in every bag and oral pivampicillin 500 mg b.d. was started. The infection responded within 72 hours, and therapy was continued for 3 weeks as is our policy.

Because of the unusual nature of the infecting organism, an environmental investigation was done. The patient admitted dropping the connector site of his line on the carpet, which constituted a violation in aseptic technique. Under these circumstances the patient should have contacted the Renal Dialysis Unit immediately, as is the policy of that unit, where the external catheter would be changed and a single prophylactic dose of antibiotic given. Swabs were taken from the patient's mouth, throat, nose, PD catheter insertion site and the carpet. A stool specimen was also taken. He also mentioned that he had eaten cottage cheese the day before the onset of his peritonitis, although he said that he had washed and disinfected his hands prior to the exchange. In view of the association of *L. monocytogenes* and soft cheeses, the remains of the cheese (which had been stored at 4°C) was also sent to our microbiology department. *L. monocytogenes* was not isolated from any of the above specimens.

This is the second documented case of *L. monocytogenes* peritonitis in a CAPD patient⁴. In contrast to the previous reported case the organism was not isolated from the blood.

This patient was immunocompromised due to his renal condition and treatment with cyclophosphamide, and

this may have made him more susceptible to opportunistic infection by *L. monocytogenes*.

In several previous cases of infections of the PD fluid by unusual organisms we have been able to trace the source of infection^{5,6} but here it was not possible.

L. monocytogenes may sometimes be confused with diphtheroids, which should not be regarded as 'contaminants' if isolated:⁴ we have found *Corynebacterium* spp. (including a strain belonging to the JK group) causing CAPD peritonitis in 3 patients over the past 14 months.

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Pericarditis due to *Salmonella dublin*

Sir,

I would like to report a case of bacterial pericarditis caused by a combination of *Salmonella dublin* and *Morganella morganii*. This rare complication of salmonella food poisoning assumes greater importance because of the increasing frequency of this infection in the community and the large population of immunosuppressed patients who may be susceptible.

A 52 year old woman with multiple myeloma was treated with three courses of chemotherapy including adriamycin, BCNU, melphalan and cyclophosphamide. Response was initially good; however, 5 months after diagnosis she developed renal failure. Haemodialysis was performed through a subclavian line whilst a surgical fistula matured. During this period she presented with clinical features suggestive of pericarditis which was