中文題目：Mycobacterium abscessus在腹膜透析病患引發之腹膜炎——一病例報告

英文題目：Peritoneal dialysis-associated mycobacterium abscessus peritonitis

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Case Presentation

A 58-year-old female developed end-stage renal disease due to diabetic nephropathy and started continuous ambulatory peritoneal dialysis(CAPD) since October, 2007. A fistula-like lesion with yellowish discharge was found over the tunnel area in March 2012. Wound debridement with PD catheter adjustment was performed. Unfortunately, she presented intermittent fever up to 39.0 degree with chills and turbid PD dialysate associated with general malaise about 3 weeks after wound debridement. Peritoneal fluid cell count revealed 286/ul(neutrophil :66%, lymphocyte:10%, monocyte:23%, eosinophil 1%). Gram stain was negative and empirical intra-peritoneal Cefazolin and gentamicin were initiated. The acid fast stain of peritoneal fluid showed positive result and TB PCR showed negative finding. Under the impression of nontuberculous mycobacterium peritonitis, Tenckhoff catheter was removed on the second day after admission. Besides, antibiotics were switched to intravenous imipenem, amikacin and oral clarithromycin. The final culture proved Mycobacterium abscessus infection. However, due to prolonged fever, abdominal computed tomography was done twice on day 11 and day 30 , showed mesentery infiltration and suspect abscess in the anterior low abdomen wall. So she received wound debridement twice during this admission. Despite of the above treatment, fluctuation of clinical symptom was still noted. Therefore, intravenous ciprofloxacin was added 18 days after admission. Amikacin was discontinued due to hearing impairment after 50 days treatment and Imipenem was discontinued after 70 days treatment. Instead of these two drugs, doxycycline was added. She was discharged on the 82th day after admission with stable condition. She still keep oral antibiotics with clarithromycin, ciprofloxacin and doxycylcine and is under regular hemodialysis.

Discussion

PD associated Nontuberculous mycobacterium(NTM) peritonitis is rare but severe with difficulty in diagnosis. Among NTM peritonitis,the leading incidence was Mycobacterium fortuitum, followed by Mycobacterium chelonae, Mycobacterium avium complex, Mycobacterium abscessus. There are 3 principle in dealing with NTM peritonitis. First is removing the peritoneal catheter; second is standard antituberculous combination therapy not useful for NTM ; third is monotherapy not suggested due to potential for the emergence of resistance. Amikacin and Clarithromycin were the most effective antibiotics, but there is no consensus on the duration of therapy. Finally, physician should be alerted the possibility of NTM peritonitis while refractory to standard antibiotic treatment to avoid severe complication.