En nuestra experiencia, los nuevos AAD son fármacos muy potentes y eficaces para el tratamiento del VHC, pero hemos observado con su uso un empeoramiento paradójico de la función renal en pacientes con ERC previa, así como un aumento de la proteinuria y microhematuria, principalmente cuando se utiliza SOF en el esquema terapéutico, un aspecto que deberá ser tenido en cuenta en estudios posteriores.

Conflicto de intereses

Todos los autores declaran no tener ningún conflito de intereses.

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Dialysis catheter related bacteriemia by *Gordonia rubropertincta* and *Sputi* in two hemodialysis patients

Bacteriemia relacionada por *Gordonia rubropertincta* y *Sputi* en 2 pacientes en hemodiálisis

Dear Editor,

Here we present two cases of bacteremia related to catheter infection by this organism.

Patient 1: 85-year-old man with end-stage renal disease on hemodyalisis via permanent tunelled catheter, was hospitalised in Nephrology for study something similar than a constitutional syndrome. He related a period of two months characterised by weakness, fever lower than 38 °C without shivering, and hyporexia with a lost of 10 kg.

The blood test showed leukocytosis (10,850/>L, normal formula), hemoglobin 12.1 g/dL, C-reactive protein 10 mg/L. The rest of analyzed parameters were normal range. Other studies, including blood cultures, tumor markers and computed topographies, were conducted without any positive result.

As the patient remained with fever, daptomycin and meropenem were initiated. After 8 days of empiric antibiotic treatment, blood cultures revealed a gram positive bacillus, which was finally identified as a *Gordonia rubropertincta*. Meropenem was stopped after a 14-day treatment, and at the time of the discharge medical, the patient was completely asymptomatic, and blood cultures were negative.

Two weeks later, the patient came back with the same symptoms, and new blood cultures revealed *G. rubropertincta* again. Meronem was administrated, and then, the tunneled catheter was removed.

Although cultures drawn from the dialysis catheter were all negative, antibiotic treatment was given for 3 weeks more and a transesophageal echocardiography was performed being negative for endocarditis.

Patient 2: A 91-year- old man, on hemodyalisis via permanent tunelled catheter, presented well-tolerated fever intradialysis with no other symptoms associated. Blood test showed leukocytes 5890 (neutrophils 79.85) and PCR 1, with the remaining results normal.

Empiric antibiotic treatment with vancomycin was initiated, and blood cultures isolated *Gordonia sputi*. After 3 weeks treatment, the patient was asymptomatic, but a new control blood culture revealed *G. sputi* again. Then, we administrated ciprofloxacin and the tunneled catheter was removed. The last blood sample test was negative.

This is the first report of catheter related bacteraemia caused by *G. rubropertincta* and *Sputti*, confirming its pathogenic potential in dialysis patients.

Gordonia species are aerobic actinomycetes, Gram-positive, catalase-positive and weakly acid-fast bacilli.[1] They are isolated from the environment, useful properties in biotechnology, but they also have been reported to cause infections. Their identification by conventional methods is

difficult, so it is believed that a number of *Gordonia* spp. infections are undetected.[2] Recently, Ramanan et al. reported 5 cases of Gordonia bacteremia colleted between 1999 and 2013. In three cases the infection was related to a Hickman catheter, and another was considered a contamination from a tunneled dialysis catheter. Interestingly, none of these species were *G. rubropertincta*, and in addition, the infection in the hemodialysis patient was considered as a contaminant.[3]

Our case report other specie, *G. rubropertincta*, that was previously known as *Rhodoccoccus rubropertinctus* until 1989. It is a rare pathogen that could cause a variety of infections in humans, not only immunocompromised even immunocompetent hosts.[3,4]

Although there is no standardized treatment due to the small number of cases reported, it seems that *Gordonia* spp. is usually susceptible to several antibiotic treatments, and it has good response rates. In our case, antibiotic treatment with daptomycin and meropenem was not enough even long-term, and removing the intravascular catheter was needed to get negative blood cultures.

In conclusion, improvement in laboratory techniques will allow identifying ubiquitous microorganisms as *Gordonia* spp., whom must be taken into account as responsible of infections in patients with hemodialysis catheters. To ensure the eradication of these microorganism, it would be advisable to remove the intravascular dispositive

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Miastenia gravis posterior a trasplante renal

Myasthenia gravis after kidney transplantation

Sr. Director:

La debilidad muscular es un síntoma que puede ser explicado por la alteración en la función del músculo, nervios periféricos, sistema nervioso central o unión neuromuscular[1]. Dentro de su estudio inicial es fundamental documentar un compromiso objetivo de la fuerza y definir la localización de la lesión y su causa, la cual puede ser inflamatoria, infecciosa, genética, metabólica, autoinmune, neoplásica o tóxica. La miastenia gravis (MG) se incluye dentro del espectro de enfermedades que afectan la unión neuromuscular, y es una entidad muy rara en el período postrasplante renal[2].

Presentamos el caso de una mujer de 29 años, con diagnóstico de enfermedad renal crónica terminal idiopática, con necesidad de terapia de reemplazo renal durante 6 años. Se realizó trasplante renal de donante fallecido haploidéntico el 11 de enero de 2010. Recibió inducción con alemtuzumab y mantenimiento con ciclosporina, azatioprina y prednisona. Un año después la paciente consultó por debilidad muscular persistente en miembros inferiores, con caídas frecuentes y compromiso fluctuante de la fuerza en miembros superiores. Posteriormente, en el curso de una infección urinaria manejada con ciprofloxacina, presentó diplopía vertical, dificultad respiratoria y disfagia para sólidos. Fue hospitalizada en la Unidad de Cuidados Intensivos por riesgo de falla ventilatoria. En el examen neurológico se observó diplejía facial, fuerza de flexores de cuello 1/5, fuerza en las 4 extremidades proximal 4/5 y distal de 5/5. Por la sospecha diagnóstica de síndrome miasteniforme se realizaron estudios que confirmaron el diagnóstico de MG (tabla 1). Se manejó con 5 sesiones de plasmaféresis y con piridostigmina, con buena evolución. En el seguimiento a 5 años su función renal es adecuada y su desempeño funcional es normal con el uso de la piridostigmina.

La MG es una enfermedad autoinmune mediada por linfocitos B que producen anticuerpos contra el receptor de acetilcolina (anti-ach). Se caracteriza por debilidad muscular que se desencadena con la actividad repetitiva y mejora con el reposo y el frío[2,3]. Frecuentemente inicia con paresia de los músculos extraoculares que puede ser aislada, o acompañarse de síntomas bulbares con disfagia y disartria, dificultad respiratoria por paresia de músculos de la caja torá-