

multiple aetiologies, in parallel to the diagnosis of glomerular disease, with a prevalence of 5.5 % (with the expected being 3.1 %). After a 10-year follow-up, the incidence of neoplasm in this population was 1.8 times higher than expected, without being able to rule out the influence of the immunosuppressive treatment received (both by the treatment itself or by accelerating the existing neoplastic process).²

Given our case and the evidence in the literature, we wanted to reconsider on how nephrologists perform the screening of neoplasms in a patient with new diagnoses of glomerulonephritis. The KDIGO guidelines^{5,6} recommend the screening of neoplasms in the case of membranous nephropathy, GEFyS and IgA nephropathy, but not in other forms, and without specifying the recommended tests to perform. Some authors propose an exhaustive study that includes a first level: chest x-ray, skin examination, breast/testicular examination, abdominal and cervical ultrasound, faecal occult blood (if positive: colonoscopy/gastroscopy). If everything is negative on a second level: mammography and gynaecological review; cystoscopy if haematuria; PSA and rectal exam (prostate biopsy if neoplasia is suspected). If everything is negative and in patients with a high risk (> 60 years, smokers, alcoholic; thromboembolism; HIV/HBV/HCV infection; prolonged immunosuppressive treatment; negative anti-PLA2R antibodies in Membranous GN): CT scan, colonoscopy, fibroendoscopy should be performed. And they recommend repeating the screening in patients who have received or receive prolonged immunosuppressive treatment, every 5 years if patients are < 60 years and every 3 years if > 60 years.⁷

According to the evidence described in the current study² with the various forms of glomerulonephritis and the multiple associated cancer, we suggest that the suspicion and investigation of the nephrologist should be greater, so as not to delay the diagnosis of an underlying cancer and to avoid the harmful consequences of an immunosuppressive treatment that can accelerate the development of neoplasia.

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Aureimonas altamirensis: The first case of peritonitis on peritoneal dialysis[☆]

Aureimonas altamirensis: primer caso de peritonitis en diálisis peritoneal

Dear Editor,

Aureimonas altamirensis (*A. altamirensis*) is a bacterial species from the caves of Altamira, Cantabria, Spain; considered as an

environmental pollutant, but isolated for the first time in biological samples in 2008 by Luong et al., it is a potential human pathogen, with a variable clinical presentation.^{1,2}

A case of peritonitis due to *A. altamirensis*, isolated in the ascites fluid of an oncological patient, has been described in the literature,³ no cases of peritonitis due to this micro-

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organism have been reported in patients on peritoneal dialysis (PD).

Below, we present a case of peritonitis due to *A. altamirensis*, in a patient on PD and we describe its clinical importance.

The patient is an 81-year-old male, with stage 5 chronic kidney disease (CKD) in PD program, with incremental modality (IPD), with a night exchange with 2.3% glucose, who presented abdominal pain of less than 24 h of evolution, along with cloudy fluid in the peritoneal exchange. Not clinical symptoms at any other level.

By Physical exam appears to be haemodynamically stable and afebrile, abdominal tenderness, preserved peristalsis, not painful at palpation and no signs of peritoneal reaction. The exit hole of the peritoneal catheter showed no inflammatory signs.

Among the complementary tests, a cell count was performed in the peritoneal fluid, which showed 827 leukocytes/ μ l, with 66% of neutrophils, so empirical treatment of peritonitis was established in relation to the technique with vancomycin and intraperitoneal ceftazidime. No imaging tests were performed.

In the culture of peritoneal fluid *A. altamirensis* resistant to gentamicin and tobramycin was isolated; sensitive to piperacillin tazobactam, ceftazidime, ciprofloxacin, trimethoprim sulfamethoxazole and amikacin. According to these results, antibiotic monotherapy with ceftazidime was maintained for 3 weeks with good response, with a cell control in peritoneal fluid of 70 leukocytes/ μ l, at 48 h.

The genus *Aurantimonas*, described by Denner et al.⁴ in 2003, covers 4 species from environmental sources, including *A. altamirensis*, a gram-negative aerobic bacillus of marine waters.⁵ Initially it was considered a pollutant derived from the environment and/or water sources, but in recent years it has been isolated in biological samples, such as in the sputum of patients with cystic fibrosis, pleural effusion, eye infections (keratitis, corneal ulcers) and even in blood cultures of immunosuppressed patients.^{2,6,7}

In a review of the literature, there are only a few cases published in which *A. altamirensis* is identified as a pathogen in humans: peritonitis in a patient with stage IV cholangiocarcinoma with peritoneal carcinomatosis³; 2 cases of pleural effusion described by Tellez-Castillo et al., with isolation of *A. altamirensis* in pleural fluid, one of the patients had a gastric adenocarcinoma⁸; lastly, 2 cases of bacteriemia due to *A. altamirensis*, one of them associated with a scrotal infection, in a pluripathological patient with stage 4 CKD⁷; and another in a patient with multiple myeloma, Bence-Jones type.²

It seems that all these cases would have as a common feature, an important comorbidity that conditions a situation of immunosuppression of variable importance. *A. altamirensis* could be considered as an opportunistic pathogen, which would cause the disease in patients weakened by an underlying disease.

From the epidemiological point of view, the patient did not report risk behaviours such as contact with animals, intake of contaminated food or untreated water, in our case we would have as the possible factors favouring infection: a dysfunc-

tional immune system, typical of CKD patients on dialysis and the presence of a foreign body (PD catheter), on which, the bacterium has the ability to generate a biofilm, as described in one of the cases of bacteraemia, where the micro-organism was isolated in a blood culture taken from a venous reservoir, of the port-a-cath type.²

In our opinion, this is a case of great interest because it is the first peritonitis due to *A. altamirensis* in a patient on peritoneal dialysis, making it clear that, although in the literature it is described as of doubtful pathogenicity in our patients (with a higher comorbidity than usual), this becomes more apparent. It should also be noted that, although there is little experience in the treatment of *A. altamirensis* infections, in our case the pattern of empirical treatment of peritonitis on PD: ceftazidime plus vancomycin, was fully effective, with the resolution of the clinical picture.

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Reversible posterior encephalopathy syndrome in renal transplanted patient with refractory arterial hypertension secondary to iliac artery stenosis[☆]

Síndrome de encefalopatía posterior reversible en paciente trasplantada renal con hipertensión arterial refractaria secundaria a estenosis de arteria ilíaca

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Dear Editor,

With regard to the article published in the journal of NEFROLOGÍA "Iliac artery stenosis after kidney transplantation as a cause of refractory hypertension and claudication"¹ and a review on posterior reversible encephalopathy syndrome (PRES),² published in *NefroPlus*, we present a case that is closely related to both publications.

Vascular problems remain one of the main complications after kidney transplantation, with an incidence of 3%–15%.³

Post-transplant arterial hypertension (HTN) secondary to decreased renal blood flow, due to the involvement of the graft artery or less frequently of the proximal aorto-iliac segment,⁴ is a correctable form¹ of HTN.

We present the case of a 62-year-old woman with a history of chronic tubulo-interstitial nephropathy and HTN controlled with amlodipine, who had received a kidney transplant and was on immunosuppressive treatment with tacrolimus, sirolimus and prednisone. At 3 weeks, she began with complaints of severe headache, vomiting and blurred vision, associated with refractory HTN, with no evidence of impairment in renal function or proteinuria. The eye fundi showed a grade 2 hypertensive retinopathy. Given the clinical sus-

picion of hypertensive encephalopathy, a brain CT scan was ordered, with findings compatible with PRES, which was confirmed by brain nuclear magnetic resonance (MNRB) (Fig. 1a and b). Due to poor blood pressure control, hypotensive treatment was intensified; complementary examinations were performed to rule out causes of secondary hypertension and tacrolimus was discontinued, although its plasma concentration remained within the target therapeutic range from admission.

The study of secondary HTN was negative, except for the echo-Doppler of the graft, which reported probable renal artery stenosis (tardus parvus morphology and increased speeds up to 200 cm/s in the proximal portion) (Fig. 2a). CT angiography posed the possibility of arteriovenous fistula, being not very assessable due to artefact (right hip prosthesis), so selective arteriography was performed that evidenced a stenosis of the external iliac artery prior to anastomosis of the artery of the graft (Fig. 2b), with reduction of the calibre of the lumen to 3.5 mm. An endovascular treatment was then performed with angioplasty of the stenosis, achieving a good morphological result. (Fig. 2c), with this procedure with/without stent being the treatment of choice in this type of pathology.⁴

At 24 h blood pressure was better controlled, with gradual disappearance of the symptomatology, which allowed the hypotensive treatment to be progressively reduced.

The MNRB, which was performed one month later, showed a significant improvement in the signs of PRES (Fig. 1c-d). In the control echo-Doppler there were no findings compatible with vascular alteration of the graft and the tacrolimus was reintroduced. The patient is currently asymptomatic and normotensive.

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