



Figure 1. Cranial nuclear magnetic resonance.

with visual abnormalities, headache, and seizures, but were resolved in a maximum of 3 weeks with no sequelae or recurrences after controlling BP and, in the first case, after modifying the immunosuppressant treatment. In our case, the patient sought treatment 4 months after developing the disease, when her anti-MBG antibodies were negative and she was not taking any immunosuppressant therapy.

In this context, it is especially important to control AHT in order to prevent a severe set of symptoms that, although they generally progress benignly, may cause potentially severe encephalopathy.

Conflicts of interest

The authors affirm that they have no conflicts of interest related to the content of this article.

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Table 1. Causes of reversible posterior leukoencephalopathy syndrome

- Hypertensive encephalopathy (pregnancy-induced AHT, malignant AHT)
- Eclampsia
- Acute or chronic renal failure
- Acute liver failure
- Sepsis
- Vasculitis and autoimmune diseases: SLE, PAN, Wegener, PSS, MCTD, dermatomyositis, microscopic polyangiitis, Schönlein-Henoch, and cryoglobulinaemia
- Haematologic diseases: HUS, TTP, sickle-cell anaemia, and lymphoproliferative diseases.
- Acute intermittent porphyria
- Ion imbalance: hypomagnesaemia, hypocalcaemia
- Blood transfusions
- Exposure to intravenous contrast dyes
- Immunosuppressant and cytotoxic drugs: amphotericin B, bevacizumab, high doses of corticosteroids, cisplatin, methotrexate, combination chemotherapy (CHOP), cyclosporine, cytarabine, gemcitabine, interferon alpha, intravenous immunoglobulins, methotrexate, rituximab, sirolimus, sorafenib, sunitinib, tacrolimus, and vincristine
- Prolonged epileptic seizures
- Erythropoietin treatment
- HIV primary infection

CHOP: cyclophosphamide, doxorubicin, vincristine, and prednisolone; MCTD: mixed connective tissue disease; PSS: progressive systemic sclerosis; AHT: arterial hypertension; SLE: systemic lupus erythematosus; PAN: polyarteritis nodosa; TTP: thrombotic thrombocytopaenic purpura; HUS: haemolytic-uraemic syndrome; HIV: human immunodeficiency virus.

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Catheter-related relapsing peritonitis due to *Kocuria varians* in a patient undergoing Continuous Ambulatory Peritoneal Dialysis

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To the Editor,

Kocuria varians is a Gram positive non-pathogenic commensal of the mammalian skin that can be present also in soil and water. *Kocuria* spp. was previously classified in the genus *Micrococcus*¹ and identification of the species by automated systems has been reported to be problematic.² Published cases of infections caused by *Kocuria varians* in the English literature are rare and consider patients with serious underlying disease.³ We report here a case of relapsing peritonitis in a patient undergoing Continuous Ambulatory Peritoneal Dialysis (CAPD) that was resolved after catheter removal.

The patient, a 70-year-old man with chronic renal failure and class III heart failure was admitted to the hospital on 26 July 2010 with turbid peritoneal dialysate, non febrile, having mild abdominal pain and positive Rebound sign at the physical examination. Leucocyte cell count showed the presence of 1200 leucocytes/ μ l (neutrophil count of 90%) in the peritoneal dialysate but subsequent culture of the fluid resulted negative. Treatment started with vancomycin 15mg/kg/5 days i.p. and aztreonam 2gr/d i.p. for a total of 20 days. On 30 July 2010 cell count was 50 leucocytes/ μ l and the patient was discharged.

3 days later however, at the first control visit, the peritoneal dialysate was turbid anew, the patient presented the same clinical findings and cell count revealed the presence of 300 leucocytes/ μ l. A Gram positive, spherical microorganism that occurred in tetrads with circular, smooth, glistening and yellow colonies was recovered from the peritoneal dialysate. The microorganism was identified as *Kocuria varians* by the VITEK 2 system. The isolate was susceptible to gentamycin, erythromycin, clindamycin, tetracycline, glycopeptides and linezolid while it was resistant to levofloxacin by the disc diffusion method. Following laboratory report, the patient was treated with vancomycin alone (15mg/kg/5 days i.p. for a total of 20 days).

Turbidity of the peritoneal dialysate did not reappear until 27 August 2010 when the patient was admitted to the hospital with generalized abdominal pain, positive Rebound sign and cell count of 550 leucocytes/ μ l. *K. varians* was isolated for the second time and removal of the peritoneal catheter followed by insertion of a new one in a different position was considered. Culture of the removed catheter was positive for *K. varians*. Vancomycin i.p. was administered, subsequent cultures were negative and the patient remained in good clinical condition since then.

Infections related to *K. varians* are uncommon but this species may act as opportunistic pathogen in immunocompromised patients with underlying diseases. Furthermore, *K. varians* is a biofilm forming bacterium⁴ thus probably complicating the antimicrobial treatment of catheter related infections. Erroneous identification of coagulase-negative Staphylococci as *Kocuria* spp. is possible and can be excluded with certainty only with the application of genotypic assays such as 16S RNA.¹ In the present case the Vitek 2 system using the new GP identification card⁵ reported a "very good identification" for all three isolations. This case report aims on emphasizing the importance of careful consideration of the laboratory and clinical procedures when rarely pathogenic microorganisms are isolated in the peritoneal dialysate of patients undergoing CAPD.

Conflicts of interest

The authors declare that there is no conflict of interest associated with this manuscript.

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Asymptomatic polyostotic Paget's disease associated with secondary hyperparathyroidism in a peritoneal dialysis patient

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To the Editor,

Paget's disease (PD) is a focal bone remodelling disorder that can affect one or more bones.¹ It is the second most common bone disease after osteoporosis, and its diagnosis usually derives from routine biochemical analyses, when elevated alkaline phosphatase (AP) levels are observed, or during imaging tests for other reasons.¹⁻³

The incidence of PD in patients with chronic kidney disease (CKD) is unknown. Few cases have been described in the medical literature,⁴⁻⁸ and in some of them PD was masked by secondary hyperparathyroidism (SHP),⁴⁻⁶ making its diagnosis quite difficult. With this in mind, we present the first case of a patient on peritoneal dialysis (PD) with coexisting polyostotic PD and SHP.