CORRESPONDENCE

Successful Management of a Chest Exit Site in a Psoriasis Patient

Editor:

Clinical guidelines recommend the use of an appropriate length of catheter for exit sites in peritoneal dialysis (PD) (1). Although exit sites are generally located on the abdomen, this location is not preferable when patients are obese or have intestinal stomas, skin folds, or particular body shapes. In such cases, an exit site is created on the upper abdomen or chest. To our knowledge, no case of modification of an exit site due to skin disease has previously been reported. We report the first case of a patient with an exit site located on the chest instead of the abdomen because of plaques of psoriasis on the abdomen. We also report that the patient was free of psoriatic exacerbation of the skin and catheter obstruction for 2.5 years.

A 71-year-old Japanese man with end-stage renal disease attributed to hypertensive nephrosclerosis began hemodialysis (HD) in 2002 and soon switched to PD. In 2007 and 2009, he was diagnosed with peritonitis and returned to HD. He subsequently requested a third course of PD because he was keen to continue his job; he was therefore admitted to our hospital. The patient had a history of psoriasis (from the age of 67 years), and had regularly attended the department of dermatology to undergo topical treatments. Upon admission, he had scaly erythematous plaques of psoriasis on his abdomen, back, buttock, and extremities but, fortunately, the skin on his chest was unaffected. We therefore planned to create an exit site on the right side of the chest where psoriatic plaques were absent. Upon surgical insertion of the Tenckhoff catheter, we constructed a long (30 cm) subcutaneous catheter tunnel in a straight line from the exit of the abdominal cavity to the exit site on the right-hand side of the chest (Figure 1). We extended the catheter by connecting two catheters with titanium connectors as described previously (2). We inserted the extended catheter, creating a long subcutaneous tunnel without bleeding, obstruction, leaking, or impaired drainage. His psoriatic activity remained stable during the perioperative period. One year later, he had peritonitis, but this was caused by a defective device rather than any technique failure. He restarted PD treatment and currently remains in a stable condition, having undergone a further 1.5 years of treatment without any problems.

Access via a chest exit site was introduced in 1992 by Twardowski (3). Because our patient had active eruptions on the abdomen, we chose the chest as the appropriate exit site (4). Psoriasis is a chronic inflammatory skin disease manifested as raised, erythematous plaques with adherent scales. The

Figure 1 — Catheter tunnel from abdomen to chest. Exit site on right chest during the operation (left panel) and long subcutaneous tunnel (dotted line) from the exit of the abdominal cavity (arrow) to the exit site (arrowhead) on chest (right panel).

infiltration of inflammatory cells causes thickening of the epidermis. We considered the thickened, fragile skin of this patient as inappropriate for the surgery. Moreover, our patient was prescribed steroid treatment for psoriasis, which we recognized as conveying a potential infection risk that we needed to avoid.

In summary, we successfully managed an exit site located on the chest in a psoriasis patient without any exacerbation of psoriasis for 2.5 years. This supports the idea that an exit site for a PD catheter can be safely created on a patient's chest with a long tunnel, even in the case of skin disease, without further eruptions.

DISCLOSURES

The authors have no financial conflicts of interest to declare.

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