CORRESPONDENCE

A Rare Case of *Roseomonas gilardii* Peritonitis in a Patient on Continuous Ambulatory Peritoneal Dialysis

Editor:

There have been only 5 reported cases of *Roseomonas* peritonitis in peritoneal dialysis (PD) patients (1–4). Our 61-year-old patient on continuous ambulatory PD (CAPD) presented with asymptomatic, cloudy peritoneal dialysate. Intraperitoneal (IP) cloxacillin and ceftazidime was initiated. Blood test results were as follows: C-reactive protein 168 mg/L, white cells $15.4 \times 10^9/L$. Dialysate cell count was 40 cells/mm³, predominantly polymorphs. Dialysate fluid cleared up on day 3, with corresponding negative cell counts. Peritoneal dialysate culture grew *Roseomonas gilardii* on day 6, resistant to ceftazidime, cefepiderazone and piperacillin, and sensitive to amikacin, gentamycin, imipenem, ciprofloxacin, cefepime, and meropenem. Clinical improvement led to continuation of IP ceftazidime and cloxacillin. Two days later, dialysate cell counts rebounded to 180 cells/mm³. The patient was switched to 2 weeks of IP meropenem and was allowed to go home with improving parameters. She was readmitted on day 22 day for culture-negative PD peritonitis that we suspected was due to inadequately cleared *Roseomonas gilardii*. Despite treatment with multiple IP antibiotics, the catheter was not salvageable.

Ours is the second case of *Roseomonas gilardii* peritonitis ever reported. *Roseomonas* is associated with contaminated water source and soil (1,2). Our patient was washing her hands under unhygienic circumstances. *Roseomonas* peritonitis presents with vague abdominal pain (1–3). Despite 2 weeks of antibiotic treatment, half of the patients in reported cases relapsed within 4 weeks and a third ended up with catheter removal (3,4). Patients with culture-negative peritonitis or with a recent history of *Roseomonas* infection may benefit from early addition of aminoglycosides, carbapenems, or fluoroquinolones. We therefore suggest IP antibiotic therapy for a minimum of 3 weeks for *Roseomonas* peritonitis. Relapses must be treated aggressively to avoid refractory peritonitis that will lead to catheter removal and septicemia.

DISCLOSURE

The authors have no financial conflicts of interest to declare.

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<http://dx.doi.org/10.3747/pdi.2016.00103>