Dear Sir,

Fungal peritonitis is a rare but serious complication in patients on continuous ambulatory peritoneal dialysis (CAPD). We report on a patient on CAPD who developed severe rectal stenosis during the course of fungal peritonitis.

Case Report

A 56-year-old Japanese woman with a history of CAPD for 1.5 years was admitted to our hospital with the diagnosis of Staphylococcus aureus peritonitis on October 8 in 1988. After admission, she received cefazolin and tobramycin intraperitoneal and consequently abdominal pain rapidly disappeared. But she began to complain of abdominal pain again on the 13th hospital day. The bacteriological examination of the peritoneal fluid on the 18th hospital day revealed Candida parapsilosis as a causative agent. An X-ray film of the abdomen disclosed a curl-type Tenckhoff catheter placed in the pelvis. We started antifungal treatment with intravenous miconazole and oral fluorocytosine. Since peritonitis did not improve in spite of the treatment, we removed the Tenckhoff catheter on the 20th hospital day. Some fibrin clots were noted in a curl portion of the removed catheter. The peritonitis improved gradually, accompanied by the decrease of abdominal pain.

On the 24th hospital day, she developed tarry stool without any symptoms such as hypotension, abdominal pain and aggravation of peritonitis. Emergent gastroduodenoscopic examination showed no significant abnormality. Melena disappeared gradually over several days. Hematocrit did not change during this episode. Barium enema examination performed on the 46th hospital day revealed severe stenosis about 5 cm in length in the upper third of the rectum (fig. 1). A colonoscopic examination showed clear stricture without mucosal changes such as atrophy, edema, hyperemia and fibrosis. A computed tomographic scan of the pelvis revealed no space-occupying lesion which surrounded the rectum. Examination of the small intestine showed no significant abnormality.

Discussion

Fig. 1. Barium enema examination reveals severe stenosis about 5 cm in length in the upper third of the rectum.
She had never had surgical treatment except placing the Tenckhoff catheter. Uremia has been well controlled by CAPD until this episode without any significant history of peritonitis. Melena occurred in the improving phase of fungal peritonitis. We consider that bleeding from the rectum causes fresh bloody stool. Our patient developed tarry stool without any accompanying symptoms such as sudden onset of pain and diarrhea which suggest ischemic colitis [1, 2]. Endoscopic findings suggest a different bleeding site than the rectum, though we could not find it out. Stenosis occurred at the rectum sited in the Douglas fossa where the Tenckhoff catheter had been placed. Although we cannot exclude the possibility of a congenital stenotic anomaly, the above findings lead to us to conclude that this regional stenosis of the rectum may have been caused by an inflammatory process of fungal peritonitis. Fungal peritonitis in patients on CAPD causes adhesion of the peritoneum and bowel obstruction [3]. Regional severe stenosis of the rectum at the Douglas fossa in patients on CAPD has not previously been reported. Our findings suggest that we should search for an inflammatory lesion in the Douglas fossa including the rectum when patients on CAPD complain of any lower abdominal symptom during the course of fungal peritonitis.

References
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