Candida famata is an uncommon yeast. Previously called Torulopsis famata and Debaryomyces hansenii, the yeast is found in many dairy products like cheese. It is an opportunistic pathogen that is commensal in the oral cavity. The fungus has been implicated in sporadic case reports as causing onychomycosis, systemic blastomycosis, extrinsic allergic alveolitis, systemic fungaemia and endophthalmitis. Candida famata has been very rarely isolated in the culture of peritoneal fluid in peritonitis. The first and only documented case report in existing literature was reported in 1994. The yeast is increasingly isolated from patients and was found in 1.45% of urinary tract infections and in about 1–2% of patients with fungaemia [6]. Recently we reported a case of mediastinitis with Candida famata [7].

Rigby and Hawley [5], while reporting the Australian experience, noted that in most patients in whom sclerosing peritonitis was complicated by peritonitis, bowel function did not recover and the patient usually died of ongoing sepsis. This was exactly our experience, in that all efforts at treatment failed and the patient eventually succumbed to his illness.

To conclude, sclerosing peritonitis complicated by fungal peritonitis is a serious complication. Newer strains of candida are being implicated. Candida famata is currently emerging as a significant pathogen in humans.

Conflict of interest statement. None declared.

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**Resumption of peritoneal dialysis after transcutaneous treatment of a peritoneal leakage using fibrin glue**

Sir,

A common cause of technique failure of peritoneal dialysis (PD) are defects in the integrity of the peritoneal membrane [1,2]. Evidence-based guidelines for the management of PD-associated leakages are not available. Here, we report a case of dialysate leakage into the abdominal wall successfully managed with fibrin glue.

A 39-year-old woman with end-stage renal disease (ESRD) and a history of primary phospholipid antibody syndrome was admitted for initiation of continuous ablatory peritoneal dialysis (CAPD). Surgical re-replacement of mitral valve prosthesis was performed in February 2005 due to endocarditis. She developed ESRD post-operatively.

The PD-catheter was inserted by laparoscopy. Four weeks after hospital discharge she was readmitted with a painful swelling in the inferior right abdominal part. Her body weight had increased during the previous 4 days, accompanied by reduced ultrafiltration.

The swelling of the abdominal wall persisted after dialysate removal. Ultrasound examination revealed a massive abdominal wall oedema and a defect in the parietal peritoneal membrane (Figure 1). Loss of integrity occurred in the region of the surgical scar. The clinical presentation and ultrasonographic findings led to the diagnosis of a peritoneal leakage in the abdominal wall. PD was stopped and haemodialysis was initiated. The dialysis solution was completely absorbed within 1 week, but the size of the peritoneal defect remained unchanged (Figure 2A).
Surgical repair of the leakage would probably be the most satisfying option in this situation. However, this would usually require a prolonged rest of PD and the risk of bleeding complications without the possibility to stop anticoagulation in the patient. Therefore we decided on a conservative management.

Fibrin glue instillation was performed. We used the following approach: after instillation of dialysis solution, and guided by ultrasound, we carefully injected 1ml fibrin glue into the space slightly above the peritoneal gap. A compression bandage was applied for 12h. Three days later a low echogenic mass became visible in the region where the fibrin glue had been injected and a thin echogenic line indicated the restoration of the peritoneal membrane (Figure 2B). After five additional days, we started to instill 500 ml dialysate per exchange increasing the volume up to 1000 ml within 10 days. She is presently doing well with nocturnal attenuated peritoneal dialysis (APD) and 1000 ml icodextrin at daytime 4 months after discharge.

Experiences with fibrin glue in peritoneal leakage are still limited. Joffe [3] described his positive experience with fibrin glue in the treatment of pericatheter leakage. As far as we know, this is the first report that demonstrates the successful treatment of early internal leakage using fibrin glue.

Fibrin glue should be considered as an effective and safe tool in cases where standard treatment of dialysate leakages have failed or if a fast resumption of PD is required.

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Combined renal replacement therapy for severe metformin-induced lactic acidosis

Sir,

This report is on a 68-year-old woman with a history of type 2 diabetes mellitus treated with metformin 850 mg thrice daily, and mild chronic renal failure, who underwent cardiopulmonary resuscitation for cardiovascular collapse because of severe metformin-associated lactic acidosis. Even after 12 h of continuous venovenous haemofiltration (CVVH), lactic acidosis persisted and the patient required increasing doses of norepinephrine. After starting simultaneous haemofiltration via a second vascular access, lactic acidosis resolved, norepinephrine infusion was discontinued and the patient subsequently made a complete recovery.

Metformin is the only medication for type 2 diabetes mellitus which has been demonstrated to reduce the risk of macrovascular complications of diabetes [1]. Lactic acidosis is a rare but potentially fatal adverse effect of metformin (30–50% mortality rate [2]) with an estimated risk of 1–15/100 000 patient-years [2]. The significance of lactic acidosis due to accumulation of metformin in renal insufficiency in the absence of other precipitating factors is the subject of controversial debate [2,3]. Tissue hypoxia triggering lactic acidosis is presumed to be present in most cases.

The patient was admitted to the stroke unit for sudden visual loss, nausea, vomiting and faintness. Soon after diagnosis of a severe metabolic acidosis (pH 6.5), the patient had a cardiovascular collapse. After successful resuscitation, she was transferred to our medical ICU, mechanically ventilated and placed on norepinephrine infusion. Blood gas analysis revealed severe lactic acidosis: pH 6.83, base excess –28 mmol/l, bicarbonate 7.9 mmol/l, lactate 35.3 mmol/l.

Fig. 2. (A) Seven days after stopping PD, a complete reabsorption of the oedema was observed. The peritoneal discontinuation was still visible. (B) Ultrasonographic finding 3 days after the application of fibrin glue. The fibrin glue appeared as an echogenic mass (arrow).