**Lactobacillus paracasei** Continuous Ambulatory Peritoneal Dialysis-Related Peritonitis and Review of the Literature

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Received 21 October 2002/Returned for modification 11 January 2003/Accepted 14 March 2003

We describe the first case of continuous ambulatory peritoneal dialysis (CAPD)-related peritonitis due to *Lactobacillus paracasei*. It occurred in a 65-year-old patient with recurrent episodes of peritonitis while he was receiving a prolonged course of intraperitoneal vancomycin. *L. paracasei* should be considered in the differential diagnosis of pathogens in CAPD-related peritonitis, especially in patients receiving prolonged vancomycin or glycopeptide treatment.

**CASE REPORT**

A 65-year-old diabetic male with end-stage renal disease commenced continuous ambulatory peritoneal dialysis (CAPD) in March 1999. In July 2001, he first reported abdominal discomfort and cloudy dialysate but no fever. Physical examination demonstrated a benign abdomen with a normal-appearing catheter exit site. Peritoneal fluid dialysate was hazy in appearance. Laboratory tests during this period revealed a WBC count of 784/µl, with 96% segmented neutrophils. Therapy with intraperitoneal aztreonam and vancomycin was initiated. Peritoneal fluid culture grew methicillin-resistant *Staphylococcus haemolyticus*. The patient finished a 2-week course of vancomycin with good results. Shortly thereafter, at the end of August 2001, he developed another episode of CAPD-related peritonitis (peritoneal fluid WBC count of 500/µl, with 90% segmented neutrophils). This time, the peritoneal fluid Gram stain showed gram-positive cocci in chains and the culture grew alpha-hemolytic streptococcus species, not enterococcus species. He was given an additional 4 weeks of intraperitoneal vancomycin, during which his abdominal complaints and peritoneal fluid leukocytosis worsened (WBC count increased to 3,200/µl, with 325/µl, with 96% segmented neutrophils). This organism was resistant to vancomycin, which had a MIC of ≥256 µg/ml by the Epsilometer (Etest) system (AB Biodisk, Solna, Sweden). The MICs of erythromycin, penicillin, levofloxacin, linezolid, and ceftriaxone were 0.047, 0.50, 0.75, 1.0, and ≥32 µg/ml, respectively. Vancomycin was discontinued, and the patient was treated with intraperitoneal penicillin G and oral levofloxacin with good results (the patient became asymptomatic, and peritoneal fluid analysis and cultures were normal and sterile, respectively).

Because of multiple episodes of CAPD-related peritonitis, the patient elected to change to hemodialysis and underwent placement of the arteriovenous fistula. One month later, he had another episode of *S. haemolyticus* CAPD-related peritonitis (WBC count of 234/µl, with 99% segmented neutrophils) for which he received another course of intraperitoneal vancomycin. Ten days later, peritoneal fluid culture again yielded *L. paracasei*. Intra-peritoneal penicillin and gentamicin were administered, and the peritoneal dialysis catheter was removed. His arteriovenous access was mature by now, and he commenced hemodialysis treatment and has had no further episodes of peritonitis.

Microbiological identification. The isolates were catalase-negative, gram-positive rods with a tendency to chain and grew equally well in both air supplemented with CO₂ and an anaerobic atmosphere at 35°C on routine media. Better growth was obtained on Columbia colistin-nalidixic acid-agar than on chocolate medium. These characteristics put the strain into the genus *Lactobacillus*. Antibiotics were stopped at that point, with the assumption that the mild cloudy dialysate effluent represented chemical peritonitis. However, he continued to have abdominal discomfort and started becoming hypotensive. Intrapерitoneal vancomycin and aztreonam were started. He was later admitted to the hospital. Repeat peritoneal fluid analysis (9 November 2001) revealed a WBC count of 325/µl (21% segmented neutrophils, 16% lymphocytes, 61% monocytes, and 2% eosinophils), and the peritoneal fluid culture on three consecutive occasions yielded pure growth of *L. paracasei*. This organism was resistant to vancomycin, which had a MIC of ≥256 µg/ml by the Epsilometer (Etest) system (AB Biodisk, Solna, Sweden). The MICs of erythromycin, penicillin, levofloxacin, linezolid, and ceftriaxone were 0.047, 0.50, 0.75, 1.0, and ≥32 µg/ml, respectively. Vancomycin was discontinued, and the patient was treated with intraperitoneal penicillin G and oral levofloxacin with good results (the patient became asymptomatic, and peritoneal fluid analysis and cultures were normal and sterile, respectively).

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Lactobacillus genus. Because identification of species within the genus is extremely difficult using conventional methods, and because the various Lactobacillus spp. have been shown to have different disease associations, 16S rRNA gene sequence identification was performed using the MicroSeq 500 gene kit (Applied Biosystems, Foster City, Calif.) and the model 3100 genetic analyzer (Hitachi, Tokyo, Japan) in accordance with the manufacturer’s specifications. Approximately 500 bp in both forward and reverse sense were sequenced for each isolate. Test strain sequences were compared against the MicroSeq 16S rRNA gene sequence database. The database contains sequences from 1,297 different species (1,187 type strains), including 20 type strains from the genus Lactobacillus. Sequence data matched the type strain of L. paracasei. Sequence data matched the type strain of L. paracasei.

Discussion. Lactobacillus spp. are gram-positive, nonmotile, nonsporulating, facultative anaerobes. They can form long slender rods or short coccolid rods, which may appear as cocci on a Gram stain (4, 7, 9). Moreover, they can often form chains and can be mistaken for Streptococcus spp. (4). We suspect that our patient (based on the Gram stain morphology of the peritoneal fluid isolates from August and September 2001) manifested Lactobacillus infection 2 months before the actual isolation of this organism from the peritoneal fluid. Previous reports have indicated that the variable Gram stain morphology and the slow and minimal growth of lactobacilli on the common media, coupled with their anaerobic requirements, can lead in many instances to their misidentification in clinical material (4).

Peritonitis is a common problem in patients with end-stage renal disease treated by CAPD. The most common organisms are usually the skin flora such as coagulase-negative staphylococci, especially Staphylococcus epidermidis, and intraperitoneal vancomycin is considered first-line treatment (8). Lactobacilli are part of the normal flora of the mouth, colon, and female genital tract but are not commonly found on the skin (1, 3, 4, 6). There have been only four cases of CAPD-related Lactobacillus peritonitis (3, 5, 7, 9). Schleifer et al. were the first to report a case of Lactobacillus CAPD-related peritonitis (9). The patient had five prior episodes of peritonitis and had received a 2-week course of intraperitoneal vancomycin before developing Lactobacillus acidophilus peritonitis. Rao et al. described a patient with CAPD-related peritonitis with Enterobacter aerogenes and Lactobacillus casei subsp. rhamnosus (5).

There was no mention of prior history of CAPD-related peritonitis or vancomycin therapy. The patient died within several days from cardiac arrest related to gastrointestinal bleeding but not related to peritonitis. Sanyal et al. reported a patient who had seven prior episodes of CAPD-related peritonitis in 2 years and had received a prolonged course of vancomycin before developing Lactobacillus rhamnosus CAPD-related peritonitis (7, 8). The isolate was initially misidentified as Enterococcus avium, emphasizing the difficulties in identification of Lactobacillus spp. The fourth case was a 57-year-old man who had received teicoplanin for coagulase-negative staphylococcus CAPD-related peritonitis (3). Two months later, he developed L. rhamnosus CAPD-related peritonitis. It is very likely that the treatment for recurrent peritonitis with intraperitoneal vancomycin or glycopeptide has provided selection pressure for emergence of organisms such as Lactobacillus species that are intrinsically resistant to vancomycin (7). Our patient denied any unusual dietary habits or hygienic practices that would have allowed infection to occur via skin route. We hypothesize that treatment with prolonged vancomycin allowed for proliferation of lactobacilli in the gut with subsequent translocation across the bowel wall into the peritoneal cavity.

Our review suggests that L. paracasei, L. casei, and L. rhamnosus are closely genetically related and cause similar diseases. In fact, because they are similar and were not identified by 16S ribosomal DNA sequence analysis, they could indeed be the same. This is in contrast to L. gasseri, L. amylovorans, and L. acidophilus, which are not closely related and are found more frequently in the normal genitourinary tract (J. Claridge III and K. Hulten, Abstr. 102nd Gen. Meet. Am. Soc. Microbiol. 2002, abstr. C-310, p. 155, 2002).

Treatment of infections with Lactobacillus spp. should be guided by the clinical presentation and susceptibility results (1, 6). There have been variable sensitivities reported in the literature, so it is advisable to test these organisms against a wide range of antibiotics (1, 2, 6). They are uniformly resistant to vancomycin but sensitive to penicillin as well as clindamycin and erythromycin, which was the case with our patient (1, 6). Previous successful treatment for Lactobacillus spp. CAPD-related peritonitis included combinations of ampicillin with gentamicin and rifampin with erythromycin, as well as rifampin and imipenem alone (3, 5, 7, 9). In general, active agents include penicillin, imipenem, aminoglycosides, clindamycin, erythromycin, and chloramphenicol (1). For serious infections, such as endocarditis, combination therapy (penicillin and an aminoglycoside) is advisable (1). Additionally, removal of the foreign body (e.g., catheter) may be necessary for cure, which was evident in our patient, who relapsed even after he received the appropriate antibiotic therapy.

Conclusion. We document the first case of L. paracasei CAPD-related peritonitis. This case should increase clinicians’ awareness of the possibility of a Lactobacillus species in patients with CAPD-related peritonitis. Lactobacillus spp. can be difficult to identify, usually occur in patients with recurrent peritonitis, and are inherently resistant to vancomycin. Prior vancomycin or glycopeptide use is a common denominator.

REFERENCES