

Q1 WHAT IS THE NEXT BEST STEP?

- A. Prescribe two week course of oral cephalexin
- B. Prescribe two week course of intraperitoneal vancomycin
- C. Monitor for one to two more days prior to diagnosing exit site infection
- D. Intensify local exit site care
- E. A or C

The correct answer is E.

The diagnosis of an exit site infection (ESI) is made with drainage around the exit site with or without erythema. This presentation is equivocal for ESI (neither a good exit site nor an obvious infection). In this case it is either appropriate to initiate empiric therapy or monitor for a short course.

Note it is very important to otherwise not delay the treatment of an ESI when the diagnosis is made. This will increase the risk of a tunnel infection and peritonitis.

The treatment of ESI starts with empiric oral antibiotic therapy against *S. Aureus* such as a penicillinase-resistant penicillin or a first generation cephalosporin. Duration of therapy is usually two weeks.

Vancomycin as empiric therapy should be avoided to prevent unnecessary exposure.

Although local exit site care can be intensified such multiple ointment exchanges and more cleaning, there is no strong data to support its efficacy in active infections.

A culture sample can be obtained only if there is drainable fluid. A swab on a dry or crusted exit should be avoided.

Further Reading:

Guest, Steven. *Handbook of Peritoneal Dialysis*. CreateSpace, 2014.