

Letters

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**Encapsulating peritoneal sclerosis—a life-threatening condition treated successfully with adhesiolysis and Jones tube insertion**

Sir,

Encapsulating sclerosing peritonitis, a life-threatening abdominal disease, is characterized by the formation of multiple fibrous adhesions. This leads to a ‘cocoon’ of fibrous tissue, encapsulating either the small or whole bowel—causing intestinal obstruction.

It was first recognized as a complication of peritoneal dialysis (PD) in 1980 [1], where it usually presents as small bowel obstruction, ascites or ultrafiltration failure. It is thought to be related to both duration of catheter use and peritoneal membrane transport characteristics, being more common in ‘fast transporters’ [2]. Convincing evidence of cure has come only from adhesiolysis, which releases the fibrous adhesions [1]. Intraluminal stenting after adhesiolysis for small bowel obstruction was first described by White in 1956. Despite the technique being modified by Munro and Jones in 1978 [3], it has never gained widespread popularity in the UK. The major complication of surgery is a high recurrence rate. In one series, 11/47 patients (23.4%) experienced recurrence, 10 undergoing a second operation, and 4 requiring a third operation [4]. The mortality is uncertain, with a wide range reported (2–56%). The rationale for our technique was to further reduce mortality and recurrence rate, and provide an alternative to drug treatments (e.g. immunosuppression) whose side effects carry considerable morbidity.

A 69-year-old woman, on PD for 10 years for ERF, was converted to haemodialysis in January 2003 due to recurrent peritonitis. In June 2003, she presented with recurrent ascites. An abdominal CT scan (below) suggested multiple encapsulating loculated collections in the abdomen. TPN was given for 6 weeks before surgical intervention. In September 2003, a laparotomy revealed encysted dense adhesions and a large pseudocyst in the pelvis entrapping the bowel. The adhesions were released and a Jones tube was placed through the entire length of the gastrointestinal tract. A Jones tube is a 3 m (18 gauge) tube with side perforations and a balloon at the distal end. During surgery, the tube was advanced via the nasogastric route through the entire length of the bowel and the distal end came out of the rectum. The balloon was inflated and the small bowel arranged in orderly fashion, so that even if fibrosis did occur, the bowel did not get entrapped. This was left *in situ* for 1 week, with TPN and haemodialysis continuing. She was discharged 7 months later and is currently well on haemodialysis, with no evidence of recurrence.

In ERF patients, encapsulating peritoneal sclerosis is a rare disease and is usually a long-term complication of peritoneal dialysis. This type of surgery has to be slow (4 h in our case) and careful, releasing bowel from fibrous bands all along its length. Adhesiolysis with intraluminal stenting should be considered as an option in the treatment of encapsulating peritoneal sclerosis.

*Conflict of interest statement.* None declared.

<sup>1</sup>Renal Unit

<sup>2</sup>Department of Surgery

<sup>3</sup>Renal Unit, UHCW, Coventry, UK

Pavan

Devulapally<sup>1</sup>

F. T. Lam<sup>2</sup>

Andrew Stein<sup>3</sup>

E-mail: dpavan2000@yahoo.com

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**Investigation of the association between oral sodium phosphate use and kidney injury**

Sir,

Recently we published a report in which we found no apparent association between oral sodium phosphate (OSP) purgative use and incident chronic kidney disease (CKD): OR (95% CI) 0.70 (0.44–1.11) [1]. Published concurrently with our study was another study by Hurst [2] that reported a potent association between OSP use and acute kidney injury (AKI): OR (95% CI) 2.35 (1.51–3.66) [2]. We were intrigued at the dramatic differences in findings, and undertook additional sensitivity analyses of our data in order to explore possible explanations. Potential sources for discrepancy include differences in timing of post-colonoscopy