Central Venous Catheter-Related Bacteremia in Chronic Hemodialysis Patients: Saudi Single Center Experience

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Abstract

Introduction: Central vein catheters (CVC) are an important means of delivering hemodialysis (HD) to patients who require immediate initiation of dialysis but are without a mature functioning arterio-venous fistula or graft. Types of central venous catheters used for chronic HD include tunneled cuffed catheters and nontunneled catheters. The risk of developing bacteremia varies with site of CVC insertion; type of device and duration of CVC use. The incidence of CRB associated with catheters was highest for femoral catheters, followed by internal jugular catheters then subclavian catheters [1].

Aim of the study: The aim of the study was to evaluate the incidence, spectrum of infecting organisms, risk factors, and optimal treatment for catheter-related bacteremia.

Methodology: This retrospective study of clinical records was conducted between January 2005 and January 2009 where all episodes of catheter related bacteremia in the preceding 4 years were a subject of our study. Data recorded for each patient included the number of catheter-days, episodes of suspected bacteremia, blood culture results, method of treatment, complications, and outcomes. All patients with CRB were treated with a 21-day course of intravenous antibiotics, with surveillance cultures obtained 1 week after completing the course of antibiotics. The CVC was removed if the patient had uncontrolled sepsis or if other vascular access was ready for use. Once the infection was controlled, catheter salvage was considered successful, leaving the original CVC in place.

Results: 93 chronic hemodialysis (HD) patients, 42 male (45.25%) and 51 female (54.8%) were included, with median age 51.67 years. During this study, there were 37087 catheter-days, with 52 episodes of CRB, or 1.4 episodes/1,000 catheter-days. Thirty-five infections (67.3%) were caused by gram-positive cocci only, including Staphylococcus aureus, Staphylococcus simulans, and Staphylococcus haemolyticus. Seventeen infections (32.7%) were caused by gram-negative rods only, including a wide variety of enteric organisms. Five CVCs were removed because of severe uncontrolled sepsis, of the remaining 47 cases; attempted CVC salvage was successful in (90.3%).

Conclusion: We conclude that in our study, CRB is relatively near the lower limit of normal range with low incidence of complication and frequently involves gram-positive bacteria. CVC salvage is significantly improved when CVC was treated by antibiotic based on blood culture results.

Introduction

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Methods

Patients, setting, and data collection

A retrospective study of clinical records was conducted for cases between January 2005 and January 2009 where all episodes of catheter related bacteremia in the preceding 4 years were a subject of our study. The study included 93 chronic hemodialysis (HD) patients from Prince Salman Center for Kidney Diseases (PSCKD), they were 42 male patients (45.2%) and 51 female patients (54.8%), Data recorded for each patient included the number of catheter-days, episodes of suspected bacteremia, blood culture results, method of treatment, complications, and outcomes. All patients with CRB were treated with a 21-day course of intravenous antibiotics, with surveillance cultures obtained 1 week after completing the course of antibiotics.

Diagnosis of CRB

1. The diagnosis of Catheter-related bacteremia was established when a hemodialysis patient with a dialysis catheter has: Clinical symptoms: fever or chills, unexplained hypotension, malaise, nausea, changes in mental status, hypothermia, lethargy, hypoglycemia, or diabetic ketoacidosis.

2. No other source of infection.

3. Definitive diagnosis of catheter-related bacteremia was made when blood cultures obtained from both the catheter lumen and
a peripheral vein grow the same organism [2], and also, there was no difference regarding the infecting organism between blood cultures drawn from the catheter or a peripheral vein if the cultures are drawn during the dialysis.

Treatment

Our protocol for treatment of CRB once it is diagnosed consisted of initial empiric antibiotic regimen included both vancomycin (20 mg /kg /weekly) and broad-spectrum gram-negative bacterial coverage (third-generation cephalosporin) Ceftazidime (1g post every session). The systemic antibiotic regimen was modified after the blood culture report was obtained.

Protocol success, was defined as catheter salvage plus resolution of symptoms within 48 h of initiation of therapy and negative cultures 1 week after completion of the regimen. The PC was removed if the patient had uncontrolled sepsis, haemodynamically unstable, or if other vascular access was ready for use.

Results

Patients demography

During the 4-year study period, 93 eligible patients were dialyzed using double-lumen, tunneled, and cuffed catheters. Average patient age was 51.67 years. Causes of ESRD included: diabetes mellitus (48.3%), hypertension (26.8%), glomerulonephritis (2.2%), unknown (13.9%), systemic lupus erythematosus (2.2%), Alport syndrome (2.2%), autosomal dominant polycystic kidney disease (1.1%), obstruction (1.1%), and other (2.2%), (Table 1).

Most PCs were used as a bridge to arteriovenous fistula in patients with newly diagnosed as ESRD or in established patients with access failure. The catheters were inserted by the vascular surgeons.

Incidence of CRB

Fifty-two episodes of CRB occurred in 93 patients during the study period (Table 2). Twenty-seven patients had one episode of CRB, and 25 patients had two or more episodes (Figure 1). There were 37087 catheter-days, and the incidence of CRB was 1.4 episodes/1,000 catheter-days.

Microbiology

A single species of gram-positive coccus was responsible for 35 of 52 episodes (67.3%) of CRB. A single species of gram-negative rod was isolated in 17 of 52 episodes (32.7%). No infections were associated with more than one organism (Figure 2).

The organisms isolated from all episodes of CRB are shown in (Table 3).

Discussion

This study confirms that bacteremia is not a frequent occurrence in our chronic HD patients with long-term, tunneled, cuffed, venous catheter access. The incidence of CRB in our center was 1.4 episodes/1,000 catheter-days which is less than the rate of 3.9 episodes/1,000 catheter-days reported by Marr et al. [3] but all these rates are considerably greater than those reported in most previous
studies of long-term, tunneled, cuffed catheters. Moss et al. [4] reported 0.70 episodes/1,000 catheter-days in patients with median catheter duration of use of 18.5 weeks. Dryden et al. [5] reported 0.5 episodes of septicemia/1,000 catheter-days. They attributed this low rate in part to the strict aseptic technique practiced by nursing staff. The factors which are responsible for our relatively accepted rate of CRB are adequate skin disinfection and good placement technique, also, It is possible that our relatively high incidence of staphylococcus, we have frequently minimized its use. In hemodialysis patients with CRB S.aureus is an antibiotic-resistant staphylococcus, [8,9] there s considerable pressure to reduce the episodes.

The source of bacteria and route for bacterial entry to the bloodstream in CRB are not clear. Bacteremia is rarely associated with exit-site infection, and most episodes occur many weeks after PC insertion, when fibroblast growth into the catheter cuff should be well established, providing an effective barrier to bacterial migration up the catheter tunnel.

It is most likely that bacteria gain entry to the bloodstream through the PC ports during catheter access despite rigorous nursing adherence to access protocol.

Several interrelated factors have been proposed to participate in the pathogenesis of CRB, these Risk factors include Staphylococcus aureus nasal colonization, longer duration of catheter use, previous bacteremia, older age, higher total intravenous iron dose, lower hemoglobin levels, diabetes mellitus and recent hospitalization. Also, Hypoalbuminemia increases the likelihood of a recurrent episode of catheter-related bacteremia among patients treated for an initial catheter-related bacteremia [6].

In our study, about half of the patients were diabetic and there was a wide variety of both gram-positive and gram-negative infections seen in this study, initial antibiotic coverage for our patients includes an agent effective against these organisms. Also, because of our relatively high incidence of staphylococcus, we have frequently used vancomycin (usually with ceftazidime) for initial empiric coverage of severe infections, With the increasing incidence of vancomycin-resistant staphylococcus, [8,9] there is considerable pressure to minimize its use. In hemodialysis patients with CRB S.aureus is an

<table>
<thead>
<tr>
<th>Organism</th>
<th>No. of Episodes</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staphylococcus epidermidis</td>
<td>26</td>
<td>50</td>
</tr>
<tr>
<td>Enterobacter cloacae</td>
<td>4</td>
<td>7.69</td>
</tr>
<tr>
<td>Pseudomonas aeruginosa</td>
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<td>7.69</td>
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<tr>
<td>Staphylococcus haemolyticus</td>
<td>3</td>
<td>5.76</td>
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<tr>
<td>Enterococcus faecalis</td>
<td>2</td>
<td>3.84</td>
</tr>
<tr>
<td>Staphylococcus aureus</td>
<td>1</td>
<td>1.92</td>
</tr>
<tr>
<td>Staphylococcus auricularis</td>
<td>1</td>
<td>1.92</td>
</tr>
<tr>
<td>Acinetobacter baumannii haemolyticus</td>
<td>3</td>
<td>5.76</td>
</tr>
<tr>
<td>Escherichia coli</td>
<td>2</td>
<td>3.84</td>
</tr>
<tr>
<td>Cedecea davisiae</td>
<td>1</td>
<td>1.92</td>
</tr>
<tr>
<td>Staphylococcus simulans</td>
<td>2</td>
<td>3.84</td>
</tr>
<tr>
<td>Pseudomonas stutzeri</td>
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</tr>
<tr>
<td>Staphylococcus sciuri</td>
<td>1</td>
<td>1.92</td>
</tr>
<tr>
<td>Staphylococcus hominis subsp. Novobiosepticus</td>
<td>1</td>
<td>1.92</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 3: Organism isolated from 52 episodes of CRB.
independent risk factor for both infectious complications and failure of bacteremia treatment [10]. A single-center, retrospective study found that, compared with patients not on dialysis, those on dialysis (379 hemodialysis and 31 peritoneal dialysis patients) were four times more likely to die from S. aureus CRB staphylococcus induced (5.3% vs. 1.3%; P <0.001) [11].

Relatively five catheters were removed early because of overwhelming sepsis. We attempted catheter salvage in many patients who presented with quite severe clinical sepsis as long as they responded well to initial therapy. Most patients were afebrile and asymptomatic within 24 to 48 hours. If the response to antibiotics was not prompt and complete, the catheter was removed.

Presumably, the low success rate of curing catheter-related bacteremia with systemic antibiotics alone is caused by persistence of the bacterial biofilm in the catheter lumen because systemic antibiotics achieve negligible antibiotic concentrations in the catheter lumen [12]. In approximately 10% of patients with catheter-related bacteremia, fever persists 48 hours after the initiation of broad-spectrum antibiotics, prompting removal of the catheter [13,14].

Infection-free survival for patients with catheter-related bacteremia treated with systemic antibiotics alone was inferior to that obtained with either immediate catheter removal [3] or catheter exchange over a guidewire [15]. However, the likelihood of a metastatic infectious complication was not increased by attempting therapy with systemic antibiotics alone [3].

It is possible that early detection and aggressive early antibiotic treatment are partly responsible for our high catheter salvage and low complication rates. Every episode of suspected bacteremia for which blood cultures were drawn was treated immediately with antibiotics, leaving no patient untreated pending culture results. This is especially important when CRB is treated on an outpatient basis and blood cultures turn positive on the day after HD. If appropriately treated with long-acting antibiotics after dialysis, outpatient can usually wait until after their next dialysis session to be redosed and only be brought back early if they have persistent symptoms of infection or if culture results are positive for organisms unlikely to be covered by the initial antibiotics.

CRB can result in life-threatening complications, including septic shock, infective endocarditis, septic arthritis, osteomyelitis, spinal epidural abscess, septic pulmonary emboli, or even death. The range in frequency is from 8, 7 to 50% depending upon the type of vascular access and the organism involved.

Metastatic complications are suspected when the patient remains febrile or has positive cultures after the catheter was removed.

In our study, no metastatic infections attributable to CRB was observed, Marr et al. [2] reported that 22% of the patients with CRB developed complications, including 10% with endocarditis. The reasons for our comparatively low rates are unclear, and this may be due to immediate treatment to every suspected bacteremia with effective antibiotic.

The relative risk for infection-related hospitalization and infection-related death is increased 2- to 3-fold among catheter-dependent hemodialysis patients compared with those using fistulas or grafts [12].

In our study, our patient died and the mortality was directly attributed to CRB. It was complicated by development of endocarditis.

1. A strict prophylaxis protocol has been reported to reduce the incidence of catheter-related bacteremia substantially in an observational study. The protocol included simple measures, such as wrapping the catheter hubs with iodine-saturated gauze for 5 minutes before removal of the catheter caps, having the dialysis nurse and patient wear masks during catheter connection and disconnection, and minimizing exposure of the catheter to air [16]. In addition, 2 types of pharmacological measures may be useful for the prophylaxis of catheter-related bacteremia. One potential approach is to use an antibiotic ointment to reduce skin flora around the catheter exit site. A second approach involves instillation of an antimicrobial solution into the catheter lumen to limit biofilm formatl is imperative for every dialysis center to develop multidisciplinary approaches to minimize the use of catheters in hemodialysis patients. However, even with optimal adherence to the Kidney Disease Outcomes Quality Initiative guidelines on vascular access, [17] there will always be a subset of patients requiring dialysis catheters.

This study confirms that in our patients, bacteremia is not a frequent complication of PC access, and a wide variety of organisms, including gram-negative rods, may be responsible for these infections. Few serious complications occur, with the notable exception of endocarditis. This study also confirms acceptable catheter salvage rates when CRB is treated immediately and promptly with antibiotic alone.

References


