Acute Peritoneal Dialysis in African Pediatric Area
Experience of Pediatric Nephrology Unit of Yopougon University Hospital (Abidjan, Côte d’Ivoire)

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Key Words
Children · Peritoneal dialysis · Renal failure · Africa

Abstract

Introduction: Acute kidney injury (AKI) is a diagnostic emergency threatening patients in a major way. Pediatric renal extra purification methods are limited in African countries due to the nonavailability of resources. Peritoneal dialysis (PD) seems to be the modality that is the most practiced for children with acute renal failure (ARF). Methodology: We conducted a retrospective study on 5 years of records of children from 1 month to 15 years who have suffered an ARF and benefited from PD while being treated at the pediatric nephrology unit of the Chu of Yopougon. ARF is defined as the condition that exists when the serum creatinine level is high or equal to 200 μmol/l outside any underlying uropathies. Results: Out of the hospitalized 88 children for AKI, 33 were on PD. Twenty-two children have been on dialysis while 9 children had to discontinue treatment due to financial problems. The sex ratio was 0.46 and the average age was 8.1. The etiologies of the AKI were predominantly glomerular diseases (45%), malaria (31.8%), and secondary interstitial nephritis of toxic origin. The indications of the PD are anuria (31%), hyperkalemia (18%), acute edema of lung (13%), and hyperuremia (13%). Eight children had automated peritoneal dialysis, 02 children underwent manual PD, and 9 children had both methods of treatment. We recorded 31 mechanical complications and 10 infections. While 8 children died, 10 recovered from AKI. Conclusion: Trained surgical medical personnel and favorable economic statuses of patients are the factors that will determine the success of PD in our country.

The authors state that there is no conflict of interest.
The two general methods of treatment for kidney disease are hemodialysis (HD) and peritoneal dialysis (PD). Of these two methods, peritoneal dialysis appears to be the most feasible in children in developing countries, because it is cost effective and does not require a high financial status [2, 3].

In sub-Saharan Africa, PD is not practiced to a great extent and so data on this activity are scarce. Until 2008, no private or public medical structure in Ivory Coast had a pediatric dialysis unit. Children weighing more than 30 kg, benefited from hemodialysis with material originally intended for adults. Since 2008, the advent of a unit of pediatric nephrology (UNP) in Abidjan (Côte d’Ivoire) allowed the practice of PD.

**Aim**

The objective of this study was to analyze the activity of PD (epidemiological, clinical, technical aspects, and evolving) in children with disease-acute renal failure in the unit of pediatric nephrology of the CHU of Yopougon in Côte d’Ivoire after five years of its initiation.

**Methods**

The UNP opened its doors to the Yopougon University Hospital in December 2008 (the first unit of pediatric nephrology of French-speaking black Africa) and with it the PD was introduced in Côte d’Ivoire. Pediatric nephrology hospitalization admission is done from the consultations of pediatric Nephrology or from children received in the emergency and/or in the pediatric unit of the CHU of Yopougon and admitted in pediatric nephrology after the doctor permanently or penalty notice. Admission may also be made from other medical structures like public or private hospitals based on the opinions of the doctors of the pediatric nephrology unit. We conducted a retrospective study of records of children from 1 month to 15 years who presented with acute renal failure (ARF); this study was supported by the team of the pediatric nephrology unit (UNP) of the CHU of Yopougon and having benefited of a PD during acute. ARF in infants and older children was defined by a condition when plasma creatinine was greater than or equal to 200 μmol/l. Children with underlying renal disease were excluded. Children with AKI and an obstructive uropathy diagnosed in antenatal (posterior urethral valves) were not included in the study. All children undergoing catheters dialysis were placed in a surgical manner under general anesthesia. The sex ratio was 0.46 (7/15); the average age of the children undergoing dialysis was 8.1 years with extremes from 1 to 15 years. The etiologies (fig. 1) of the AKI in our unit were the glomerular diseases (45%), malaria (31.8%), and secondary tubulointerstitial nephritis to the use of toxic drug. The indications to use the PD modality were anuria (31%), hyperkalemia (18%), edema acute lung (13%), and hyperuremia (13%). All catheters were placed surgically in the operating room after consultation by a pre anesthetic by a senior surgeon pediatrician [5]. The Tenckhoff catheter was used in 20 children (20/22) and was used at 02 Drain in Redon. The median time to onset of complications was 03 days. Peritonitis and infections (08/10) were diagnosed after clinical data confrontation (turbid liquid and or abdominal pain and or fever) and as a result of the tests done in the bacteriological laboratory, 4 germs were isolated in the dialysate fluid (table 1). The techniques used were automated peritoneal dialysis (APD) in 8 children, manual peritoneal dialysis (CAPD) in 2 children, and 9 patients were associated with APD and CAPD. 17 of 22 patients have presented a complication with a prevalence of 77. Complications have resulted in transient discontinuation of the PD (17 cases), final judgment (8 cases), and a repeat surgery for placement of catheter (9 cases) resulting in an increase in the length of hospital stay and expenses. The overall trend (fig. 2) after causal and symptomatic support associated with the PD shows that the rate of recovery of renal function in 10 patients is 45%; four patients evolved toward chronic renal failure while 8 patients died (36%). The main complications were of mechanical origin (lack of drainage from the peritoneal cavity) in 31 cases and infectious complications in 10 cases (table 1). The etiologies of deaths in our study were the AEL (2 cases), hyperkalemia (2 cases), anemia (01 case), and 2 deaths were due to infections (nosocomial Infection in Acinobacter and complicated Tunelites of secondary sepsis with disorder of coagulation).

**Results**

During the period of study, the UNP made 252 hospitalizations including 88 for insufficient renal acute failure. 22 children have been dialysis on 33 who had an indication of PD (average 4–5 dialysis patients per year). 9 children of the 11 who are not undergoing dialysis summers, the financial problems of the parents (27.3%) was the cause of non-realization of PD-01 child has been evacuated abroad according to the will of the parents and 01 child hemodynamic instability against indicated general anesthesia. The sex ratio was 0.46 (7/15); the average age of the children undergoing dialysis was 8.1 years with extremes from 1 to 15 years. The indications to use the PD modality were anuria (31%), hyperkalemia (18%), edema acute lung (13%), and hyperuremia (13%). All catheters were placed surgically in the operating room after consultation by a pre anesthetic by a senior surgeon pediatrician [5]. The Tenckhoff catheter was used in 20 children (20/22) and was used at 02 Drain in Redon. The median time to onset of complications was 03 days. Peritonitis and infections (08/10) were diagnosed after clinical data confrontation (turbid liquid and or abdominal pain and or fever) and as a result of the tests done in the bacteriological laboratory, 4 germs were isolated in the dialysate fluid (table 1). The techniques used were automated peritoneal dialysis (APD) in 8 children, manual peritoneal dialysis (CAPD) in 2 children, and 9 patients were associated with APD and CAPD. 17 of 22 patients have presented a complication with a prevalence of 77. Complications have resulted in transient discontinuation of the PD (17 cases), final judgment (8 cases), and a repeat surgery for placement of catheter (9 cases) resulting in an increase in the length of hospital stay and expenses. The overall trend (fig. 2) after causal and symptomatic support associated with the PD shows that the rate of recovery of renal function in 10 patients is 45%; four patients evolved toward chronic renal failure while 8 patients died (36%). The main complications were of mechanical origin (lack of drainage from the peritoneal cavity) in 31 cases and infectious complications in 10 cases (table 1). The etiologies of deaths in our study were the AEL (2 cases), hyperkalemia (2 cases), anemia (01 case), and 2 deaths were due to infections (nosocomial Infection in Acinobacter and complicated Tunelites of secondary sepsis with disorder of coagulation).
Discussion

Studies of Olowu [5] in Nigeria reveal the financial problem that is present there; in Aloni only 10.9% of patients have the ability to gain access to PD and in the Congo [6] only 26% of patients have that capacity. The conditions of admission to the UNP are not always within the reach of the financial capacities of the parents. In fact, only two parents had health insurance but even in that scheme had to pay up front and then collect the reimbursement from the insurance company. In our developing country, glomerulopathies, which are the main etiology for AKI, is found to predominantly affect children in the age group 2 to 15 [7]. Acute tubular necrosis is the principal renal manifestation of severe malaria caused by Plasmodium falciparum, responsible of AKI in our study and is responsible for 31.8% of the AKI in PD. Malaria is present in work on renal failure in Group III of malaria countries. Gastroenteritis (ANOCHIE in Nigeria and ASSOUNGA in the Congo as etiology of the AKI in the child) and hemolytic uremic syndrome (HUS) diarrheal post (the most frequent etiology of the AKI in chil-
dren in Europe [10, 11]), have not been found as causes for AKI in our study probably because diarrhea gets treated in pediatric services and the absence of HUS may be due to our eating habits that make foods are prepared over cooked. The indication of PD in the AKI is strongly influenced by hyperkalemia due to the risk of cardiac arrest by pace disorders and acute lung and cerebral edema leading to salt and water retention. PD was a renal extra purification technique used in our unity because it is the only method available; also, it has the benefit of being just a simple procedure where the peritoneum can be easily hyperpermeable in infants and small children [3] and this all the more the production of vascular first is often difficult. Redon drains have been used in low-weight children (<10 kg) and for which the diameter of the Tenckhoff catheter we had was not suitable.

The Tenckhoff catheter has the advantage of having fewer problems of dysfunction and the catheters that are placed at the bedside without a cuff have a long life [12]. The installation of the KT is a time key that is vital in the realization of the PD program. It is necessary to have a surgeon as part of the team coordinated by the nephrologist in order to avoid complications. Peritonitis was treated according to the recommendations of the international society for peritoneal dialysis [13] (with empirical antibiotics aimed at both Gram positive and Gram negative germs). Ceftriaxon was used as first-line intravenous antibiotic as involving surgical staff, nurses and biologists, and by guaranteeing only by ensuring efficient multidisciplinary training involving surgical staff, nurses and biologists, and by creating awareness in every state on the importance of pediatric nephrology in our countries.

**Conclusion**

PD is an extra kidney cleansing technique that deserves to be developed in West Africa, particularly in the pediatric environment. The cost of the PD remains important because of the lack of a social security body. It appears at the end of our study that the success of the method and the decline in the mortality rate can be guaranteed only by ensuring efficient multidisciplinary training involving surgical staff, nurses and biologists, and by creating awareness in every state on the importance of pediatric nephrology in our countries.

**References**

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