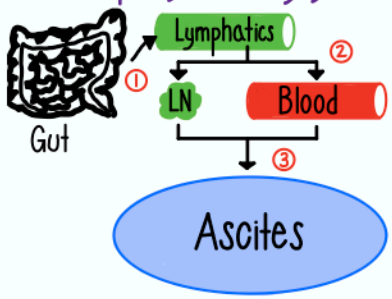
Spontaneous Bacterial Peritonitis

*IVAlbumin In SBP If:
- Cr>1
- BUN>30
- T. Bili>4

Epidemiology
- Pts w/ Cirrhosis + Ascites
- High Mortality In SBP + Shock Or Renal Dysfunction

Risk Factors:
- High MELD, Child Pugh C
- Ascitic Protein <1.5g/dL
- Prior SBP or Variceal Bleed

Pathophysiology



①Bacterial Translocation From Gut Into Lymphatics

②Bacteria Enter Systemic Circulation or Colonize Mesenteric LNs

③Bacteria Seed Ascitic Fluid

Clinical Manifestations
- Systemic Infection:
  - Fever, Sepsis,
  - Isolated Leukocytosis
- Altered Mental Status
- Abdominal Pain + Tenderness

Patients Can Be Asymptomatic (~15%)

Diagnosis
- Ascitic Fluid Neutrophil Count ≥250 +
- ⊕Ascites Fluid Culture +
- No Surgically Treatable Infection (2° Bact. Peritonitis)

	⊕Ascites Cx	⊖Ascites Cx
Neut ≥250	SBP or 2° Peritonitis	Culture Negative Neutrocytic Ascites (CNNA)
Neut <250	Bacterascites	Normal

DDx
- Neut ≥250, ⊕Ascites Cx
  - SBP: ↓Protein, ↑SAAG, Monomicrobial
  - 2° Bact. Peritonitis: ↑Protein, ↓Gluc, ↑LDH, Polymicrobial
- Neut ≥250, ⊖Ascites Cx (CNNA)
  - SBP: Para Post-Abx, Poor Cx Yield, Spontaneous Resolution
  - Carcinomatosis: ↓SAAG, ⊕Cytology
  - Peritoneal TB: ↓SAAG, ↑Lymphs

Tx:
- Treat Infxn: Start CTX If Neut ≥250
- Prevent HRS/AKI: Give IVAlbumin*, Stop Non-Selective Beta-Blocker

Ppx:
- Use Cipro Or TMP/SMX If...
  - Prior SBP
  - Cirrhosis + GI Bleed
  - Ascitic Protein <1.5g/dL + Cr>1.2, BUN>25, Na<130 Or Child-Pugh Class C + T. Bili>3.