- diagnosis
  - absolute neutrophil count in peritoneal fluid >0.25x10^9 cells/L (250 cells/mm ^{3})
  - Gram stain positive in only 10-50% of patients
  - culture positive in <80% of patients (not needed for diagnosis)
- prophylaxis: consider in patients with:
  - cirrhotic with GI bleed: ceftriaxone IV daily or norfloxacin BID x 7 d
  - previous episode of SBP: long-term prophylaxis with daily norfloxacin or TMP-SMX
- treatment
  - IV ABx (cefotaxime 2 g IV q8h or ceftriaxone 2 g IV daily is the treatment of choice for 5 d; modify if response inadequate or culture shows resistant organisms)
  - IV albumin (1.5 g/kg at time of diagnosis and 1 g/kg on day 3) decreases mortality by lowering risk of acute renal failure

Biliary Tract

Jaundice

• see *Table 2, G5* and *Figures 15 and 16*

Definition

• yellowing of the skin, sclera, and/or mucous membranes due to abnormal deposition of pigmented bilirubin

Signs and Symptoms

• dark urine, pale stools: suggests that bilirubin elevation is from direct fraction
• pruritus: suggests chronic disease, cholestasis
• abdominal pain: suggests biliary tract obstruction from stone or pancreatic/biliary tumour (obstructive jaundice)
• painless jaundice in the elderly: think of pancreatic cancer
• kernicterus: rarely seen in adults due to maturation of blood brain barrier

Investigations

• blood work: CBC, bilirubin (direct and total), liver enzymes (AST, ALT, ALP, GGT), liver function tests (INR/PT, PTT, albumin), ± amylase/lipase
• U/S or CT for evidence of bile duct obstruction (e.g. bile duct dilation)
• more detailed evaluation of bile duct ± surrounding structures like pancreas:
  - MRCP: non-invasive
  - EUS: sensitive for stones and pancreatic tumours
  - ERCP: invasive, most accurate, allows for therapeutic intervention
  - PTC: if ERCP fails (endoscopic access not possible)

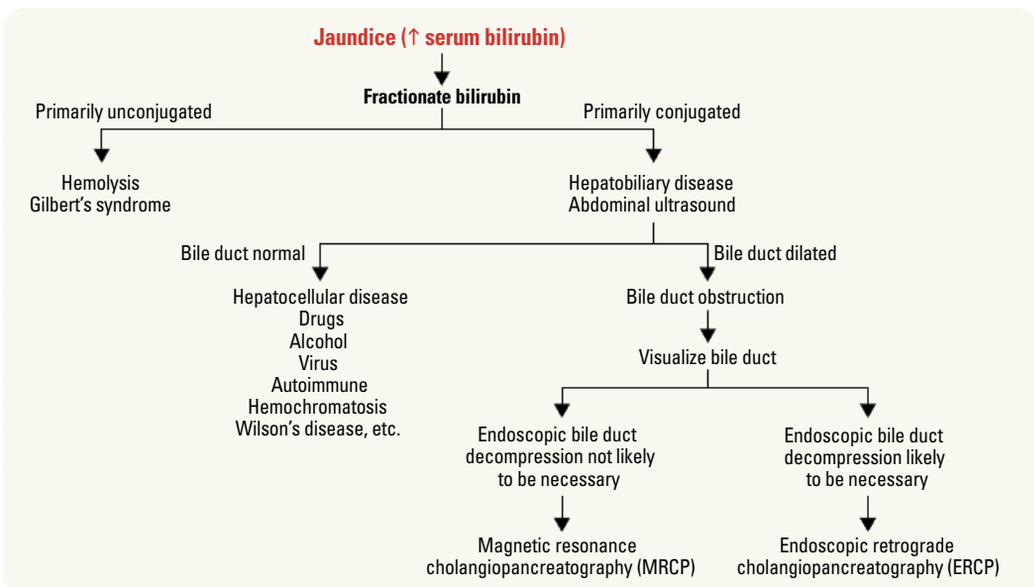

Figure 15. Approach to jaundice

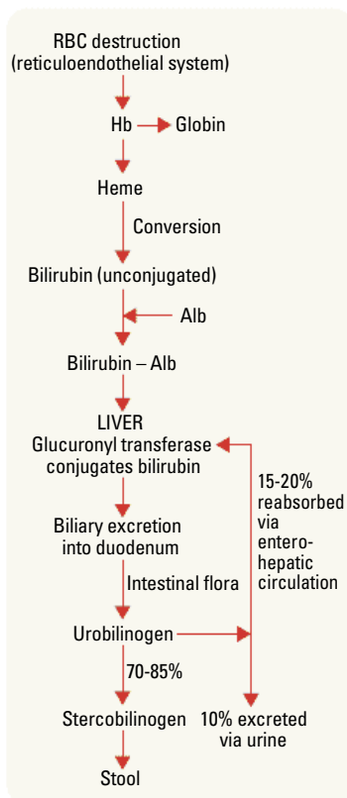

Figure 16. Production and excretion of bilirubin