Background

The Therapeutic Goods Administration (TGA) has received several reports of serious adverse events associated with the use of Peripherally Inserted Central Catheter (PICC) Lines.

TGA received a medical device adverse event report from a hospital concerning an incident during a procedure to insert an Arrow brand PICC Line in a child.

The report advises that the outer winding of the indwelling wire separated from the inner core and embolised into the pulmonary artery of the patient after the length of line was trimmed to an appropriate length for a small patient. Subsequent scans showed the presence of wire fragment in the pulmonary artery that was successfully removed.

The TGA's Medical Device Incident Report Investigation Scheme (IRIS) reports prior to this latest set were single reports to the TGA in 2004 and 2005.

The TGA investigated similar incidents in 2002 and 2005, and on three previous occasions has issued warning about the risks of cutting catheter guidewires in PICC and central lines. The advice was also published through the "TGA News" information sheet with recommendations that wherever possible shortening of the catheter should be avoided, but if necessary to do so, the manufacturer's instructions should be very carefully followed.

The TGA is investigating these incidents.

Actions required by Area Health Services

1. Wherever possible shortening of the catheter should be avoided, but if necessary to do so, the manufacturer’s instructions should be very carefully followed.
2. AHS to respond to SABS email address within 2 working days of receipt of this alert.