



Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety
Information

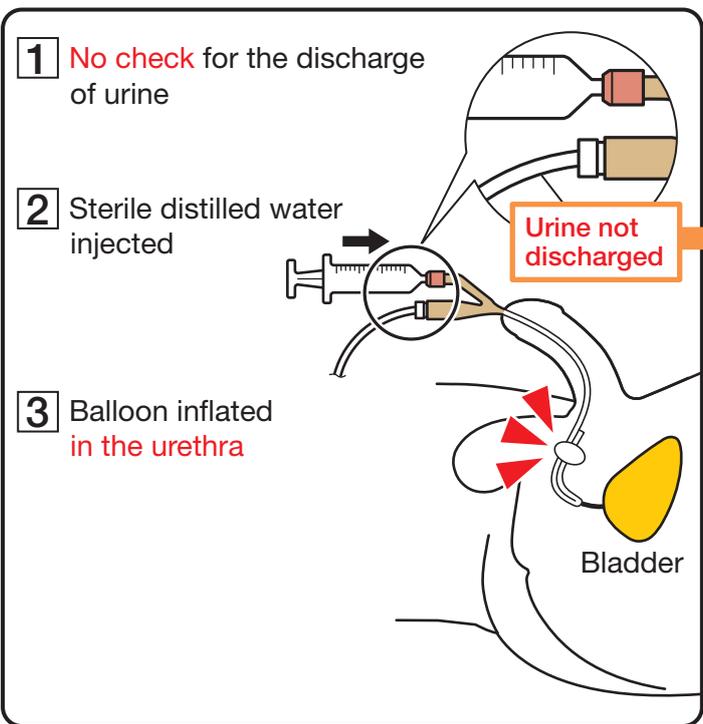
Urethral Damage Caused by
an Indwelling Bladder Catheter
(1st Follow-up Report)

No.142, September 2018

Information about the urethral damage caused by an indwelling bladder catheter was provided in Medical Safety Information No.80 (July 2013). As 49 similar events have been reported since then, information about this issue is provided here again (information collection period: from June 1, 2013 to July 31, 2018). The information is compiled based on “Recurrence of Events and Occurrence of Similar Events” in the 47th Quarterly Reports.

Cases have again been reported in which damage to the urethra resulted from inflation of the balloon without checking for the discharge of urine when putting an indwelling bladder catheter in place. All the patients were male.

Image of case



Main Factors Behind the Decision to Inflate the Balloon Without Checking for Urine Discharge	Number of Cases
Thought that the catheter inserted was long enough	27
Felt no resistance when inserting the catheter	15
Thought that there was no urine in the bladder because the patient had just urinated or was on nil by mouth	15

◆ In some cases, more than one of these background factors was involved.

Urethral Damage Caused by an Indwelling Bladder Catheter (1st Follow-up Report)

Case 1

The nurse inserted a 14Fr indwelling bladder catheter all the way to the base into a patient who had been placed under general anesthesia. Although no urine was discharged, the nurse was able to insert it without any resistance, so they judged that it had entered the bladder. Bleeding occurred immediately after sterile distilled water was injected into the balloon, so the catheter was removed. A urologist subsequently examined the patient and diagnosed urethral damage, resulting in the patient's length of stay being extended by six days.

Case 2

The nurse inserted a 14Fr indwelling bladder catheter into a patient who had been placed under general anesthesia, but felt resistance and removed it. The nurse switched to a 12Fr catheter and tried again to insert it, but felt resistance, so inserted a 10Fr catheter instead. Although the discharge of urine could not be confirmed, the nurse was able to insert the catheter all the way to the base, so they judged that it had entered the bladder. Bleeding occurred when sterile distilled water was injected into the balloon, so the catheter was removed. A urologist examined the patient and diagnosed urethral damage, resulting in the patient's planned surgery being postponed.

Preventive measures taken at the medical institutions in which the events occurred

- Medical staff will not inflate the balloon if no urine is discharged, even if there is no resistance upon inserting the indwelling bladder catheter.
- If it is difficult to place an indwelling bladder catheter, nurses will request assistance from a urologist without delay.

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See the Project website for details.

<http://www.med-safe.jp/>

* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.

* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

