Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/Adverse Event Information

Medical Safety Information

No.164, July 2020

Central Venous Catheter Guide Wire Left Behind

Sixteen cases have been reported in which a guide wire was left in the patient's body because the physician forgot to remove it when inserting a central venous catheter (information collection period: from January 1, 2015 to May 31, 2020). This information was compiled on the basis of the content featured in the Analysis Themes section of the 59th Quarterly Report.

Cases have been reported in which a central venous catheter guide wire was left in the patient's body.

Image of case 1

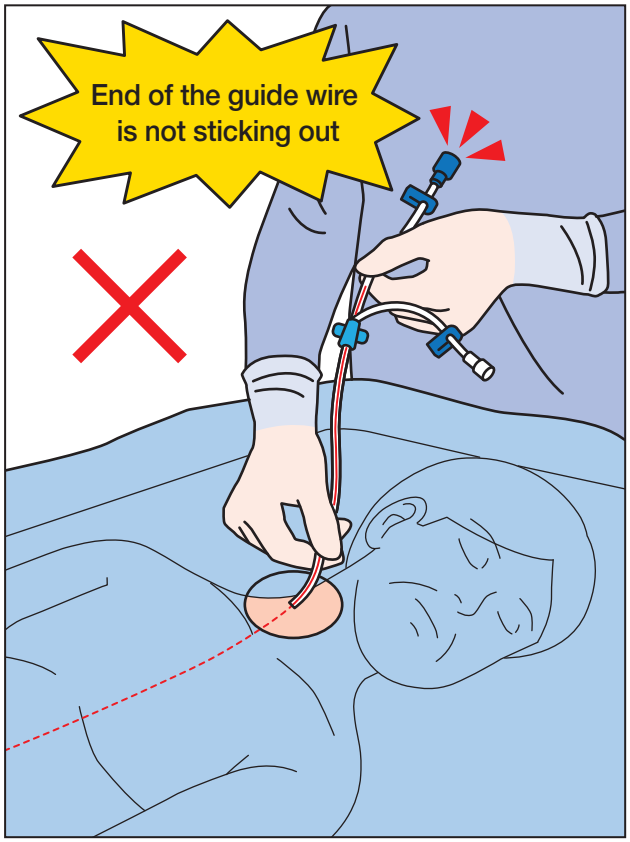
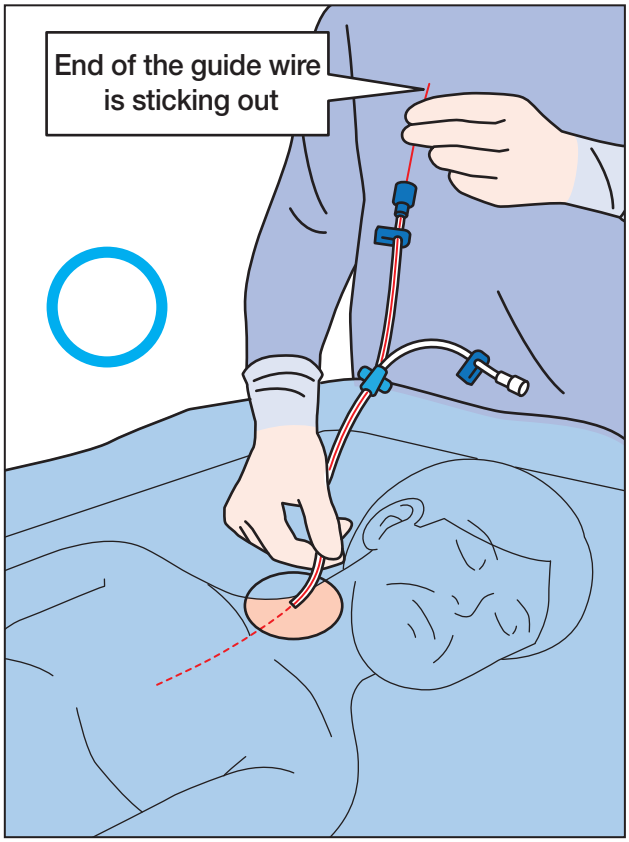


Illustration of central venous catheter insertion



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Case 1

The physician inserted the catheter into the internal jugular vein without first withdrawing the end of the guide wire from the end of the central venous catheter. After inserting the catheter, the physician realized that they had forgotten to remove the guide wire and confirmed from a chest X-ray image that the guide wire had been left in the patient's body. The physician consulted a radiologist, who performed a fluoroscopy and found that the guide wire left behind extended from the superior vena cava into the right femoral vein. The guide wire was subsequently recovered.

Case 2

The physician inserted a central venous catheter into the right femoral vein. After insertion, the physician checked the position of the catheter using fluoroscopy, but did not notice that the guide wire had been left behind. The patient underwent a CT examination during their admission, but neither the physician, the radiological technologist, nor the radiologist noticed that the guide wire had been left behind and the patient was transferred to another medical institution. The patient became febrile three days after transfer, so the central venous catheter was removed and, when a CT examination was carried out, the physician found that the guide wire left behind extended from the femoral vein to the superior vena cava. The patient was readmitted to the hospital and guide wire was recovered.

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

- **Withdraw the end of the guide wire from the end of the central venous catheter and ensure that it is held firmly when inserting the catheter.**

The measure above is example. Please consider initiatives suitable for your own facility.

* 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.

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