



Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

No.80, July 2013

Urethral Damage Caused by an Indwelling Bladder Catheter

15 cases have been reported involving damage to the urethra when an indwelling bladder catheter was put in place (information collection period: from January 1, 2010 to May 31, 2013; the information is partly included in “Individual Theme Review” (p.126) in the 31st Quarterly Report).

Cases of damage to the urethra resulting from inflation of the balloon without checking for the discharge of urine when putting an indwelling bladder catheter in place have been reported.

Procedure for putting an indwelling bladder catheter in place

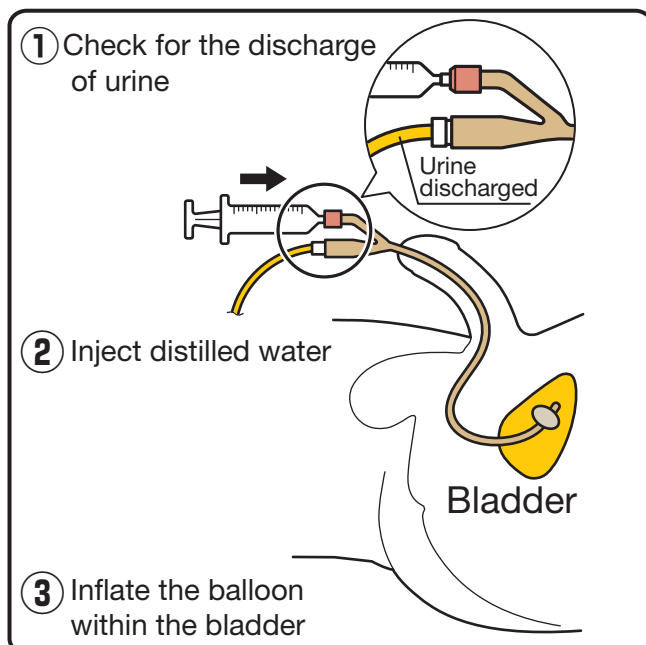
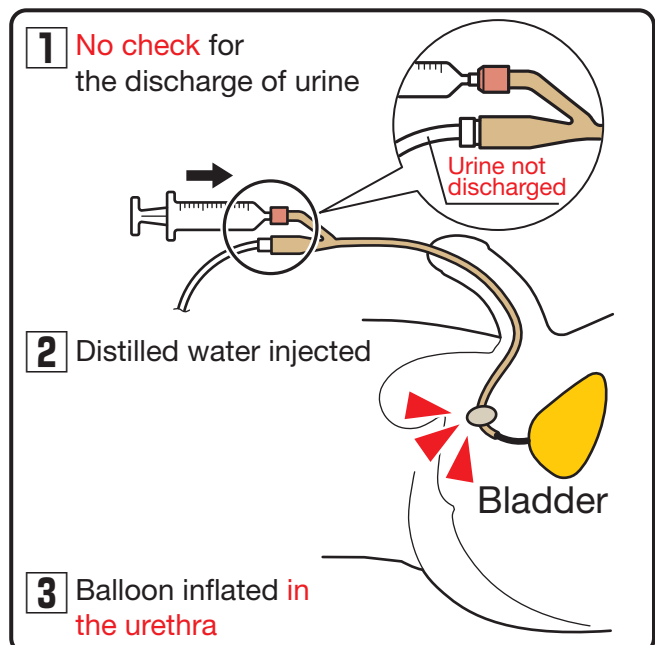


Image of case



Urethral Damage Caused by an Indwelling Bladder Catheter

Case

The nurse inserted a 12Fr indwelling bladder catheter into a patient under general anesthesia. The prescribed procedure for putting an indwelling bladder catheter in place was to check for the discharge of urine and then to inject distilled water into the balloon, but the anesthesiologist injected the distilled water without checking for the discharge of urine. When the catheter was being fixed with tape, the patient was found to be bleeding from the urethral opening, so a urologist was asked to examine him and the patient was diagnosed with damage to the prostatic urethra. An 18Fr indwelling bladder catheter was inserted for the purpose of hemostasis and the planned surgery was carried out.

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

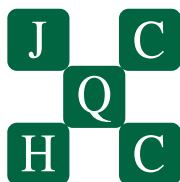
- When putting an indwelling bladder catheter in place, a sufficiently long catheter will be inserted and a check will be carried out for the discharge of urine, before injecting distilled water into the balloon.
- If urine is not discharged, the medical personnel will wait for a while and then confirm that urine is being discharged before inflating the balloon.

* 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 quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project.

<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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