Fig. 1. Paceport® pulmonary artery catheter with 2.6 cm × 1 mm cylindrical core extruded from the right ventricular lumen (Lot No. 3S12A 7522, Model No. 93A-931H-7.5F).

securing adequate intravenous and intraarterial access, the right internal jugular vein was cannulated uneventfully. While routinely flushing the catheter ports before insertion into the patient, a yellow core was noted to be protruding from the distal right ventricular lumen of a Paceport® pulmonary artery catheter (Baxter, Irvine, CA). This core did not come out with flushing using the flush valve of the transducer setup, rather it took a manual “power flush” from a syringe to fully dislodge the core from the distal right ventricular lumen (fig. 1). The core was a solid cylindrical object that was 2.6 cm in length, 1 mm in diameter, with smooth flat ends. The core appeared to be made of the same yellow plastic used to make the catheter itself. This core was most likely a remnant from the manufacturing process. Another catheter was obtained, flushed, and inserted without incident. The rest of the anesthetic and surgery were uneventful.

We were fortunate that the lumen core was extruded during the flushing of the catheter ports before insertion into the patient. Had this not occurred until the catheter was inserted into the patient, it could have resulted in any one of several complications. Closer examination of the catheter revealed no additional problems. The manufacturer has no reports of a similar nature involving the same model and lot number. Moreover, the manufacturer has implemented several process improvements to prevent the type of occurrence reported herein. The Product Insert Data Sheet, included with each catheter, strongly recommends preinsertion testing of the catheter.

It is imperative that we pay close attention to the pulmonary artery catheter itself when flushing the ports because they may contain more that just heparinized saline solution.

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References


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In Reply—Baxter appreciates the opportunity to provide additional comment regarding the above referenced manuscript. As a responsible medical device company, Baxter is interested in learning of experiences with its products. The occurrence reported in the manuscript is an isolated one. Baxter has no reports of a similar nature involving the same model and lot number of the device. In the interest of patient safety, Baxter implemented several process improvements to prevent the type of occurrence reported. Of importance, Baxter’s product insert data sheet, which is included with each catheter, recommends preinsertion testing of the catheter.

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Who Is Ella Mae?

To the Editor—We have had reusable laryngeal mask airways (LMA) at our hospital for several years. Recently this one (fig. 1) returned to our department after being gas sterilized.

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Fig. 1.