Incidental Discovery of Retained Triple Lumen Catheter Guidewire

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DESCRIPTION

A 30-year-old male with type 1 diabetes mellitus presented with diabetic ketoacidosis, acute kidney injury, and respiratory failure requiring emergent venous access and intubation. A left femoral triple lumen catheter (TLC) was inserted by an internal medicine resident with attending supervision. There were no reported complications. Fourteen days later, interventional radiology retrieved an “extra wire” via the right internal jugular vein at the time of hemodialysis catheter insertion. This

Figure 1. Transthoracic echocardiogram, demonstrating the guidewire (thick arrows) in the inferior vena cava (thin arrow) and right atrium (asterisk).

Figure 2. Chest X-ray, with the retained guidewire in the inferior and superior vena cava (thin arrows) and left subclavian intravascular catheter (thick arrows).

was determined to be the guidewire from the prior femoral TLC placement. On retrospective review of imaging, the guidewire can be seen on an echocardiogram (Fig. 1, online video) and multiple chest radiographs (Fig. 2) obtained between TLC insertion and guidewire retrieval. This “inattentional blindness,” in which an unexpected visual finding is overlooked when focusing on a different task, was a substantial contributor to this medical error.¹ The patient did not suffer any complications from the retained guidewire, and the error was disclosed to the patient. While more than 5 million central venous catheters are placed in the United States yearly,² intravascular loss of complete guidewires represents a rare and serious complication that is preventable with standardized insertion technique and adequate trainee supervision.³

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Compliance with Ethical Standards:

Conflict of Interest: The authors declare that they do not have a conflict of interest.

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