



Management of Inadvertent Arterial Catheterisation Associated with Central Venous Access Procedures

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KEYWORDS

Carotid artery injuries;
Central venous catheterisation;
Subclavian artery injuries;
Treatment outcome;
Endovascular repair

Abstract **Objective:** This study aims to describe the clinical management of inadvertent arterial catheterisation after attempted central venous catheterisation.

Methods: Patients referred for surgical or endovascular management for inadvertent arterial catheterisation during a 5-year period were identified from an endovascular database, providing prospective information on techniques and outcome. The corresponding patient records and radiographic reports were analysed retrospectively.

Results: Eleven inadvertent arterial (four common carotid, six subclavian and one femoral) catheterisations had been carried out in 10 patients. Risk factors were obesity ($n = 2$), short neck ($n = 1$) and emergency procedure ($n = 4$). All central venous access procedures but one had been made using external landmark techniques. The techniques used were stent-graft placement ($n = 6$), percutaneous suture device ($n = 2$), external compression after angiography ($n = 1$), balloon occlusion and open repair ($n = 1$) and open repair after failure of percutaneous suture device ($n = 1$). There were no procedure-related complications within a median follow-up period of 16 months.

Conclusion: Inadvertent arterial catheterisation during central venous cannulation is associated with obesity, emergency puncture and lack of ultrasonic guidance and should be suspected on retrograde/pulsatile catheter flow or local haematoma. If arterial catheterisation is recognised, the catheter should be left in place and the patient be referred for percutaneous/endovascular or surgical management.

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The use of central venous catheters is widespread to provide venous access, nutritional support or to manage

perioperative fluids. Central venous access procedures are associated with inadvertent arterial puncture or catheterisation in up to 6% of patients when using external landmark techniques,¹ with subsequent development of haemorrhage,² pseudoaneurysm,³ arteriovenous fistulation,⁴ arterial dissection,⁵ neurological injury^{6,7} and severe^{8,9} or even lethal^{10,11} airway obstruction.

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