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# Fractured peripheral venous catheter: a rare incident

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**Fractured peripheral venous catheter: a rare incident**

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## Image in medicine

Although placement of peripheral venous catheters (PVC) for the purposes of administration of drugs and fluids during anesthesia, is seen as a benign part of the daily practice, such simplest procedure process risks. A written informed consent was obtained from the patient to report this case. A 29-year-old woman was admitted to the obstetric emergency ward for an excision of a large abscess of the right labia majora under spinal anesthesia. Venous access was assured with a 20 G cannula inserted in the median cubital vein. During the surgical procedure, the patient was free to move her arms. At the end of the surgery, the anesthesist nurse removed the device with some resistance but it was immediately recognized that a large piece of the catheter was missing. A venous tourniquet was immediately placed proximal to

the insertion point. Following palpation of a distinct cord-like object under the skin, it was decided to remove off the broken piece surgically by performing a venotomy under local anesthesia (A,B). PVC fracture is an unlikely and under-reported complication. Fragment of the catheter can break off and travel through the venous circulation into the heart and pulmonary circulation, causing abnormal heart rhythms or potentially leading to pulmonary embolism and even death.

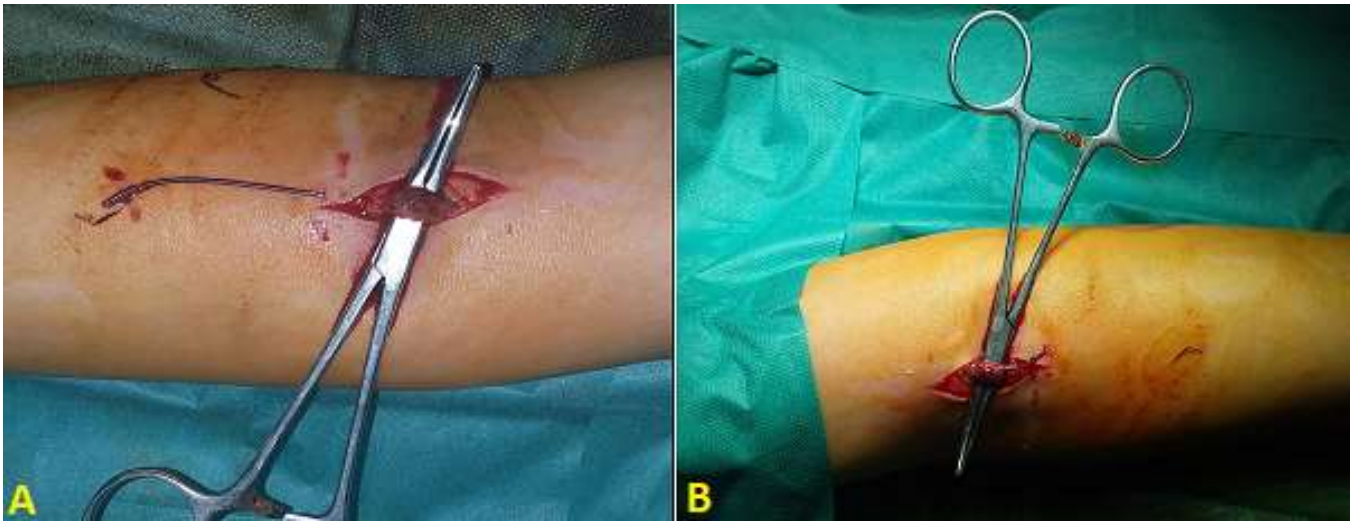


**Figure 1**: subcutaneous fat necrosis, on the right breast 23 years after 60 Gy cobalt radiation