PCPS/ECMO Cannula Accidental Removal

Key points for safe use

(Case 1) The cannula was removed due to insufficient cooperation between the surgeons since the surgeon who inserted the cannula and the surgeon who secured the cannula with sutures were different.

1. Precautions for securing the cannula

- Share the progress of the procedures, etc.

The cannula was not secured!

The cannula was dislodged!

After completion of the cannula insertion and initiation of assisted circulation, the cannula may move due to its weight, etc., so decide the procedure in advance to prevent dislodgement such as holding the cannula until it is secured with sutures.
2. Precautions when transferring and moving

- When transferring or moving, decide a coordinating leader or staff assignment in advance.

In order to avoid cannula removal during transfer or moving, decide the roles and perform simulation for troubles, etc. in advance.
(Case 3) When changing the body position, the cannula was pulled and came out about 10 cm.

3 Precautions when changing the body position

- When changing the body position, communicate verbally and check the position of the cannula and the placement of the circuit.

There have been reports of instances that led to severe symptoms such as bleeding and hypotension due to accidental dislodgement of the cannula.

The Ministry of Health, Labour and Welfare (MHLW) issued a notification concerning training program on ECMO and ventilator related to PMDA Medical Safety Information No.62

- Administrative Notice dated April, 1, 2021
  Implementation of the Training Program for Medical Personnel Responding to Critically Ill Patients with COVID-19