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Endovascular management of Inadvertent Subclavian Artery Catheterisation

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Case Study:

60 year lady on hemodialysis, with thrombosis of AV fistula and right IJV , planned for insertion of u ncuffed left IJV catheter under ultrasound guidance. The puncture into the left IJV with non-pulsatile venous blood and catheter insertion was donewith good flow from both ports . Chest roent genogram to check catheter position, the tip of the catheter was not seen to cross the midline and a ppeared to be lying over the aortic arch. Blood gas analysis from the catheter was suggestive of arter ial cannulation. Computed Tomography Angiography (CTA) showed the catheter tip in the ascendin g aorta . Radiocontrast injection via the catheter revealed a flow of contrast in the aortic arch. Digital substraction angiography visualized the catheter entry point into the arterial system in the proximal l eft subclavian artery adjacent to the origin of the left vertebral artery which being the dominant ves sel. Placement of a covered stent was considered . There was risk of stroke owing to proximity of o rigin of the vertebral artery and a dual artery stent placement was planned. The position of the tip of the catheter was confirmed and an AMPLATZ exchange wire was passed ,an EVERCROSS 10mm x40 mm balloon was passed over the exchange wire and positioned over the inadvertent puncture site in the left subclavian artery. The catheter was removed and the balloon was inflated, as there was extr avasation of dye. Multiple inflations were needed. Post inflation injection revealed sealing of the punc ture site and no further extravasation of the dye. Stent placement was deferred. The patient was sta ble post procedure and discharged from the hospital after a week. Conclusion
While endovascular placement of covered stent provides an efficient form of treatment,
balloon dilatation and tamponade is an effective modality and may negate the requirement of covere d stents and related costs if successful.