***Case report***

ACCIDENTAL COMMON CAROTID ARTERY CANNULATION DURING ATTEMPT OF INTERNAL JUGULAR VENOUS CATHETER CANNULATION

**ABSTRACT**

Central venous catheter placement is a common procedure, performed on a daily basis. It is relatively a safe procedure, with low complication rate. However serious complications can occur, especially in cases of inadvertent artery cannulation. The consequences can be devastating, if the situation is not immediately recognised and managed. The preferred sites for cental venous cannulation are the right sublavian or the right internal jugular vein. The central venous cannulation is usually performed with landmark technique. This paper presented a case of a female patient after abdominal surgery, who had an attempt of placement of central venous catheter in the intensive care unit, because the need for optimal delivery of drugs, fluid and parenteral nutrition. During the attempt of the right internal jugular vein cannulation, the carotid artery was cannulated. The situation was immediately recognised and managed by a vascular surgeon. The patient recovered completely without any neurological decifit.

**KEY WORD:** central venous catheter placement, unintentional artery cannulation, complications, ultrasonographic guidance.

**INTRODUCTION**

Central venous catheter (CVC) placement is a common procudere, which is performed by anesthesiologists and other medical professionals almost on a daily basis. It is relatively a safe procedure, but certain complications are possible. Complications during CVC placement have been cassified as either infectious, thrombotic or mechanical. The preferred sites for CVC placement are the right subclavian or the right internal jugular vein. The most common mechanical complication during CVC insertion in the internal jugular vein include arterial puncture, haemathoma and pneumothorax (1).

The carotid artery puncture is a rare, but well recognised complication associated with jugular venous catheter insertion. Arterial puncture during internal jugular vein cannulation is reported to be between 6.3% and 9.4%. Fortunately, the incidence of arterial cannulation is less than 1%. Despite its low occurrence, it can have serious consequences, if it is not immediately recognised and properly managed (2).

To avoid the incidental artery puncture during CVC placement, the use of ultrasonographic guidance is recommended, that enables higher rates of success on the first attempt and a decrease in the complication rates during CVC placement [3]. In this paper we present a case of a female patient after abdominal surgery. She needed a CVC placement for optimal delivery of drugs, fuid and parenteral nutrition. During the attempt of the right jugular vein cannulation, the right common carotid artery was cannulated instead.

**CASE REPORT**

A 62-year-old female patient was referred to our medical centre for an elective surgery due to diagnosed colon cancer. From associated diseases, she had an arterial hypertension and hyperlipidemia, both on per oral medications. She had a laparoscopic cholecystectomy and gynecological surgery in the past. The preparation for surgery by anesthesiology team was performed according to standard protocol. The planned surgery was a right hemicolectomy due to coecal cancer. By agreement with the anesthesiologist, we did not decide for CVC placement before surgery. The surgery went well, a right hemicolectomy with anastomosis was performed. After the surgery, she was transferred to the intensive care unit (ICU). Because of poor peripheral venous access and the need for optimal delivery of drugs, fluid and parenteral nutrition, we decided for CVC placement.

An attempt of CVC placement in to the right internal jugular vein was performed, with landmark technique, without ultrasound guidance. During cannulation, dilatation and insertion of the CVC in to the right internal jugular vein, the pulsatile flow of blood was obtained through the CVC and it was suspected, that the carotid artery has been punctured. The blood sample was obtained for gas analysis and the arterial blood was confirmed. The procedure was performed under local anesthesia, the patient was awake and fortunately she did not show any neurological deficit. The CVC was left in place on the right side and the vascular surgeon was consulted immediately. The vascular surgeon and anesthesiologist then decided together, that surgical exploration of the right carotid artery would be the best option. At surgical exploration it was found, that the internal jugular vein was not punctured nor damaged, the common carotid artery was cannulated. The vascular surgeon removed the central venous catheter from the carotid artery and sutured the defect in the arterial wall. During the whole surgery, the neurological monitoring was performed and no neurological deficit was noticed. The patient fully recovered and the rest of the postoperative course was uneventful. The patient had no neurological symptoms during and after the surgery.

**DISCUSSION**

Central venous catheter (CVC) placement is a common procedure, which is performed on a daily basis, mainly because of the need for optimal drug and fluid delivery. The procedure is relatively safe, but some complications can occur. One of possible complications is accidental artery puncture. In the attempt of CVC placement in to the internal jugular vein, accidental carotid artey puncture and cannulation can occur. If not recognised and managed immediately, it can have serious consequences. Iatrogenic trauma to the carotid arteries may provoke severe bleeding, arterial dissection, emboli, thrombosis or brain stroke (3). In anesthetized patients, inadvertent arterial cannulation that is not promptly recognized and managed can lead to debilitating irreversible complications. Thrombembolism can occur after up to 48 hours after trauma of the carotid artery and it is not necessarily, that neurological symptoms are evident immediately after the arterial catheterization. Close neurological monitoring for up to 48 hours is suggested in those cases (4,5).

In our case, we attempted to place CVC in to the right internal jugular vein with the landmark technique, without ultrasonographic guidance. After puncturing the vein, we obtained a dark, non-pulsatile blood, so we thought, that the right vein was punctured. Then we dilated the vein and inserted a CVC. However, immediately after the insertion of the catheter, a pulsatile blood flow in to the catheter was noticed. We suspected, that the carotid artery has been punctured. The blood gas analysis confirmed, that the artery has been cannulated.

Physical findings of arterial puncture include the following: enlarging haematoma or ecchymosis in the region, which can obstruct the airway, diminished distal pulses, tracheal deviation, vocal-chord palsy, or a palpable thrill or bruit. In some cases the classic signs of arterial puncture may be absent, and therefore dilatation and cannulation of the artery may occur. Confirmation of venous blood prior to dilatation and cannulation is critical also in patients with chronic pulmonary obstructive disease, who normally have lower arterial oxygenation and/or in patients with hypotension (6). To avoid incidental puncture of the carotid artery instead of internal jugular vein, many published guidelines and recommendations support the clinical utility of ultrasound-guided internal jugular vein puncture. The use of appropriate cannulation techniques involving real-time ultrasonographic guidance for avoiding puncturing of the common carotid artey has been widely reported in the literature (6). Classic teaching of looking for dark non-pulsatile blood can be inaccurate in hypotensive, hypoxic patients and patient with kidney failure. Also when a collapsible vein overlies the carotid artery, a through puncture can occur (3, 7). In our case, the vascular surgeon confirmed, that the internal jugular vein was in front of the common carotid artery, but interestingly the vein was not punctured through nor damaged. It is recommended, that a vascular surgeon is consulted in case of inadvertent carotid artery cannulation. Surgical or endovascular repair of the artery is the best management of inadvertent carotid artey cannulation with minimum complications (1).

Some authors (Guilbert et al) report, that in cases of removal of the catheter from the artery and manual compression, complications may occur in up to 47% of patients. No complications were reported in patients, treated with surgical exploration and surgical repair of the damaged artery wall (5).

**CONCLUSION**

Complications after catheter-related carotid arterial trauma can be devastating, if not immediately recognised and managed. Ultrasoud guidance should be utilized, when performing a central venous catheter insertion in the internal jugular vein. If inadvertent carotid artery cannulation occurs, the central venous catheter should be left in place and the vascular surgeon should be consulted.

**ETHICS APPROVAL AND CONSENT TO PARTICIPATE**

The consent to participate has been obtained from the patient.

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