

A peculiar manufacturing defect in catheter mount

Sir,

Equipment defect has been mentioned in the literature, and it can sometimes lead to patient morbidity if not detected on time. As a result, there has been a great emphasis on checking of the anaesthesia equipment^[1] before their use. Guidelines have been formulated by Association of Anaesthetists of Great Britain and Ireland to prevent such mishaps. Here, we would like to mention a case of a catheter mount which had a peculiar manufacturing defect.

A 42-year-old patient with the American Society of Anesthesiologists physical status 1 was posted for laparoscopic inguinal hernioplasty. The catheter mount (Clarimount, product code: 41201, Dashmesh Sonali Healthcare Pvt. Ltd., Mumbai, Maharashtra, India) was kept wrapped until immediately before use, as currently recommended to prevent foreign objects entering and blocking it. After confirming the patient details and attaching routine monitors, it was noticed that the just opened, unbroken, undamaged and patent catheter mount had two patient ends and no machine end as seen in Figures 1 and 2. Timely detection prevented any untoward mishap. Had it been noticed after induction of anaesthesia, it could have resulted in transient apnoea to the patient due to difficulties in mask ventilation as it would be cumbersome to ventilate the patient without the catheter mount.

Literature search was conducted using a database of Medline, PubMed, Embase, and Ovid and in Google

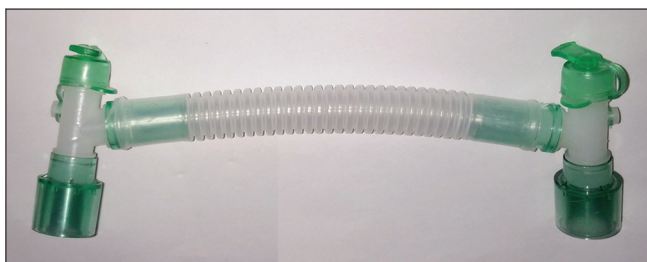


Figure 1: Catheter mount with two patient ends

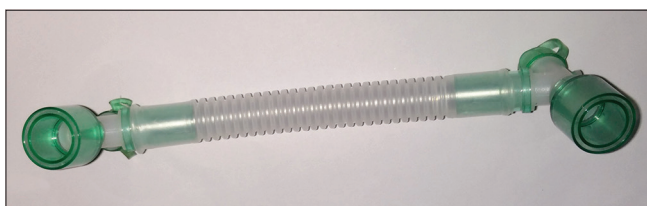


Figure 2: Note the patency at the both ends

Scholar. The search terms were 'defective catheter mount', 'catheter mount with two patient ends' and 'blocked catheter mount'. No reference was found on catheter mount with two patient ends, although many references were available for blocked catheter mount.^[2-5]

We place our reliance on the anaesthesia circuit being patent and quality checked before supply, but this incident clearly shows that we cannot take such things for granted. We should, therefore, consider all components, from all manufacturers, as having the potential of being damaged or defective and should be checked before start of any case.

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Conflicts of interest

There are no conflicts of interest.

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REFERENCES

- Dorsch JA, Dorsch SE, editors. Equipment checking and maintenance. In: Understanding Anaesthesia Equipment. 5th ed. New Delhi: Lippincott Williams and Wilkins, Wolters Kluwer Business; 2008. p. 931-54.
- Ravi PR, Shouche S. A curious case of blocked catheter mount. *Med J Armed Forces India* 2013;69:313-4.
- Puttick N, Malik D. Blocked catheter mount. *Anaesthesia* 2007;62:638.
- Thomas R. A blocked catheter mount. *Anaesthesia* 2001;56:188-9.
- Kapoor H, Date A, Gujarkar K, Wagh H. Defective heat moisture exchange filter causing 'block' in anaesthesia breathing circuit. *Indian J Anaesth* 2016;60:66-8.

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