

Adult Implanted/Tunneled Port and Catheter Removal Page 1 of 5

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care.

Note: This algorithm is intended to be used by the Acute Care Procedures Team • Notify on-call vascular surgeon, prior to procedure for any infected ports > 3 years old in the event assistance Yes-Inspect site of with troubleshooting is needed if the device is stuck port hub or • Remove port or catheter, send tip for culture, leave Ensure patient catheter for wound pocket open, and pack with iodoform or gauze has been placed Signs of significant • Consult wound care, if needed Infection --> on antibiotics. infection? • Ensure wound care appointment in place prior to signs of Patient pending tunneled catheter If not, contact erythema, discharge from procedure area or inpatient area removal (subclavian, femoral, primary team. fluctuance or intraperitoneal, or internal jugular [IJ]) drainage Proceed with See Page 3 for closing site **Bleeding During** ➤ **Removal** and/or • Ensure anticoagulation Yes Thrombosis (if port still Post-Port medication ordered if Provider to assess: Remove needed and patient is Removal presence of thrombosis. If • Vital signs¹ for fever or any signs of Is asymptomatic⁵ start Assessment not, contact primary team. sepsis, erythema, fluctuance or drainage catheter safe to anticoagulation and do • Communicate with Vascular • History of anticoagulation² use remove? not remove port unless Defer to Vascular Surgery provider on-call • Visualization³ of device on chest x-ray, symptoms worsen) Surgery for guidance regarding location/position CT chest/abdomen/pelvis, or PET scan Indication to safely remove port of clot to safely remove port • History of thrombosis on available upper of infection or extremity doppler or CT chest/abdomen/ thrombosis? pelvis • Date and location of device placement, and continued need for device⁴ • Patient history No See Page 2 for Port and Catheter Removal Process **Coagulopathy Threshold**

Procedure	Minimum platelet threshold	Threshold to infuse platelets during procedure	INR
Port catheter removal	20 K/microliter	10-20 K/microliter	2
Tunneled catheter removal	20 K/microliter	10-20 K/microliter	2

¹ Heart rate > 110 bpm or < 60 bpm, oxygen saturation < 92% and systolic blood pressure < 95 mmHg or > 170 mmHg

²Refer to Peri-Procedure Management of Anticoagulants algorithm prior to procedure

³ Devices not captured on imaging and/or palpable on physical exam need to be sent to obtain a recent chest x-ray to visualize device before removal procedure

⁴ For devices placed at MD Anderson that are still needed for access, contact provider/surgeon directly who placed device to assist with troubleshooting

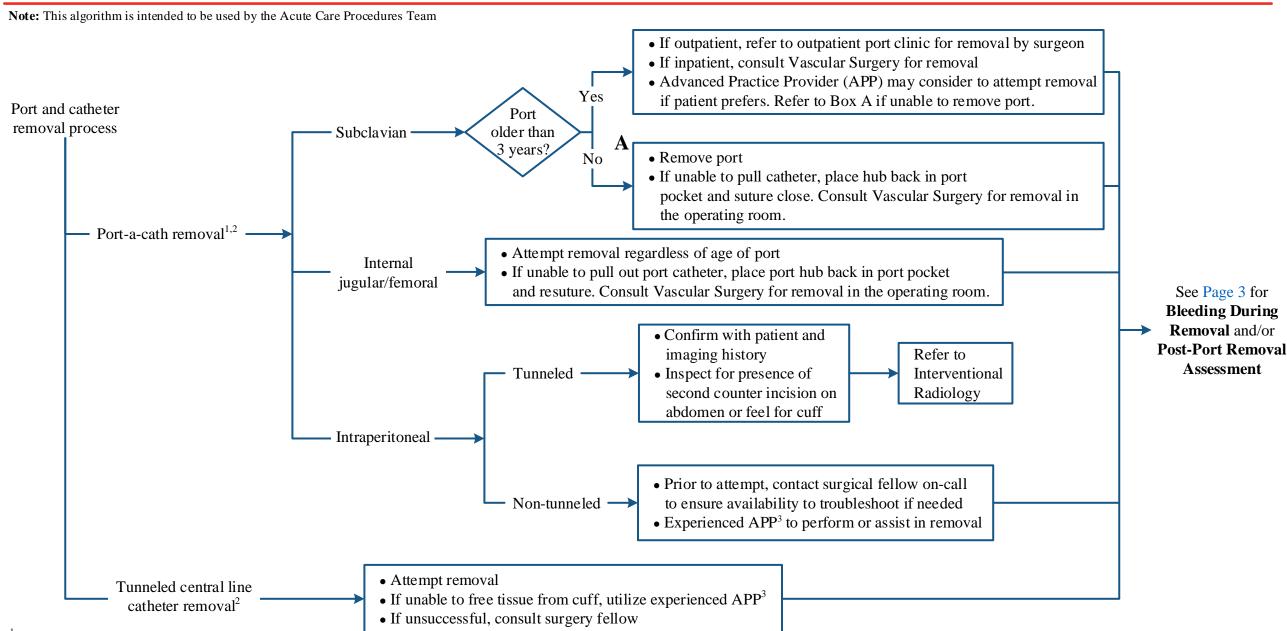
⁵ No pain and/or swelling



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Do not perform a catheter exchange utilizing a port-a-cath

² Patient must be supine for procedure

³ APP with > 1 year experience in port removal

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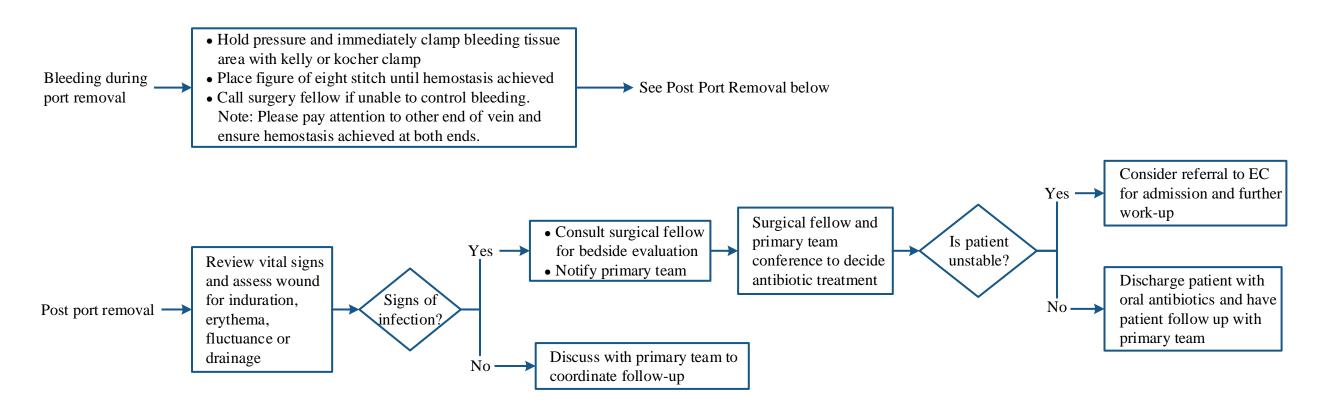


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SUGGESTED READINGS

- Bishop, L., Dougherty, L., Bodenham, A., Mansi, J., Crowe, P., Kibbler, C., . . . Treleaven, J. (2007). Guidelines on the insertion and management of central venous access devices in adults. *International Journal of Laboratory Hematology*, 29(4), 261-278. https://doi.org/10.1111/j.1751-553X.2007.00931.x
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- Cerini, P., Guzzardi, G., Galbiati, A., Stanca, C., Del Sette, B., & Carriero, A. (2017). Endoluminal dilation technique to remove stuck port-A-cath: A case report. *Annals of Vascular Surgery*, 43, 317.e1-317.e3. https://doi.org/10.1016/j.avsg.2017.04.042
- Hong, J. H. (2009). An easy technique for the removal of a hemodialysis catheter stuck in central veins. *The Journal of Vascular Access*, 11(1), 59-62. https://doi.org/10.1177/112972981001100112



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DEVELOPMENT CREDITS

This practice consensus statement is based on majority opinion of the Acute Care Services Department at the University of Texas MD Anderson Cancer Center for the patient population. These experts included:

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