Interventional Removal of Intravascular Medical Devices: Methods and Technical Success

Purpose: Evaluation of the technical success rate and complications when retrieving dislocated intravascular foreign bodies.

Material and Methods: Between 1999 and 2015 38 patients (21 female; 17 male; Age: 17 – 92; Average 54.3 years) underwent an extraction of intravascular dislocated foreign bodies, which were not lost during a radiological intervention. The extracted material included 29 port catheters, 3 tips of tunneled dialysis catheters, 2 stents, 2 guide wires, 1 CVC tip and 1 AS occluder device. Various catheters for repositioning and extraction were used. The access was transarterial as well as transvenous. Technical success was defined as complete removal of the foreign body.

Results: The technical success rate was 92.1 % (35 of 38). In 17 patients an additional catheter was necessary to reposition the foreign body in order to make it accessible for the extraction catheter. In one case a stent was relocated and remodeled within the patient and was not extracted. In another case we experienced a dislocation of a small fragment of the port catheter into the distal parts of the pulmonary artery, which couldn’t be extracted. A guide wire could not be extracted as it was already adhered with the vessel wall. Peri-interventional complications were not documented.

Conclusion: The percutaneous extraction of dislocated intravascular foreign bodies is technically successful and poor of complications. Interventional therapy can avoid surgical removal.

Key points:
- In most cases surgical removal can be avoided.
- The gooseneck-snare catheter was mainly used for the extraction of intravascular foreign bodies.

Zusammenfassung

Ziel: Evaluation des technischen Erfolgs und der Komplikationsrate bei der Bergung von intravasal disloziertem Fremdmaterial.


Introduction

Central venous catheters (CVC) as well as subcutaneous port systems have found wide acceptance in both inpatient and outpatient medical care. For example, the number of implanted central venous catheters is estimated to be about five million in the USA alone [1]. In addition there are numerous implants for arterial intervention, e.g. stents for intravascular supply of stenosis.

Although the dislocation rate of endovascular implanted medical devices is 0.3–2.9% compared with rate of up to 20% for frequently occurring complications such as hemorrhage, thrombosis and infection related to implantation [2–5], the absolute number of dislocated medical devices has increased with the amount of implanted material. In contrast, the complication rate of dislocations is very high, at 60–71% [6, 7]. Serious complications include cardiac arrhythmia and thromboembolism [8]. A 1977 review article described 16 fatalities (e.g. fulminant pulmonary embolism, septic thrombosis and perforation of the right atrium) caused by dislocated medical devices [7]. Therefore retrieval of foreign material should be performed whenever possible. Improvement of materials over time (e.g. port tubing systems) has tended to reduce the risk of material breakage. Since central venous catheters are especially poorly accessed for retrieval via surgery, a radiological procedure is the preferred intervention [9]. Various methods for interventional retrieval of medical devices have been previously described, including Dormia baskets, lasso catheters and forceps [7].

The current study is based on a highly heterogeneous study population and discusses technical retrieval and the complication rate for retrieving stents and atrial umbrellas. As a supplement to existing literature, this study additionally investigates the intervention time and related dose area product, as well as the success rate and peri- and post-interventional complications encountered when retrieving intravascularly dislocated foreign bodies.

Materials and Methods

All patients between 1999 to 2015 were retrospectively analyzed for whom a radiological interventional foreign body retrieval was performed at two centers (6 / 32 patients per center). The inclusion criterion was that the dislocated material was not directly the result of a radiological intervention. This resulted in a patient pool of 38 patients (21 females, 17 males; aged 17 – 92 years; average: 54.3 years of age). The foreign material included 29 port catheters, three tunneled dialysis catheters, two stents, one CVC tip, two guidewires and an umbrella to occlude an atrial septal defect (Table 1).

All interventions were performed by 12 radiologists of the two institutes, each with at least one year's experience in interventional radiology. Ethical approval was obtained from the relevant ethics committee for this retrospective study.

After presentation of a written consent form by the parent or guardian, all patients were first given a conventional X-ray or fluoroscopic examination to provide exact documentation of the location of the foreign material. The interventions were performed exclusively under inguinal local anesthesia with placement of a sluice of varying sizes (6 to 24 F). The size of the sluice depended on the size of the foreign body to be removed. It had to be taken into account that when removing port catheters, for example, a loop is created when the object is caught by the lasso catheter, thus requiring twice the diameter. In principle, a somewhat larger valve was used to avoid the risk of losing the foreign body again if the sluice was changed. Sluices up to a size of 24 F can be used (for aortic prosthesis implantation). Bedside monitoring was performed when retrieval was via the right heart (measurement of oxygen saturation, blood pressure and echocardiogram). If the foreign material could not be directly retrieved using the lasso catheter, additional catheters were employed (SOS Omni catheter [SOS Omni Selective Catheter, angiodynamics, Latham, NY, USA], pigtail catheter [Optimed, Ettingen, Germany], RIM catheter [Cordis, Miami, FL, USA]), Catcher forceps catheter Osypa AG, Reinfelden, Germany). These were used to guide the foreign body into a more suitable section of blood vessel to permit retrieval with a lasso catheter. Lasso catheters have been particularly used for non-traumatic retrieval of foreign bodies from the right atrium and vena cava. The extent of the peripheral location of the foreign body in the lung determined the likelihood that additional catheters were required to effect non-traumatic retrieval. Manipulation using the lasso catheter in the pulmonary trunk or the pulmonary arteries should be avoided as much as possible. Therefore an additional catheter was required in 76% of cases of retrieval from a pulmonary artery (13/17 patients). The diameter of the vessel segment containing the foreign body determined the lasso catheter (Gooseneck Snare/Microsnare, Covidien, Plymouth, USA). Once the foreign body was captured with the lasso under fluoroscopy (Fig. 1), depending on size, it was removed via the lumen of the sluice or removed from the venous bloodstream together with the sluice. Due to the risk of trauma, removal together with the sluice in the

Table 1 Overview over the type and location of the intravasal foreign body.

<table>
<thead>
<tr>
<th>foreign body</th>
<th>n (%)</th>
<th>location</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>port catheter</td>
<td>29 (76.3%)</td>
<td>SCV</td>
<td>3 (7.9%)</td>
</tr>
<tr>
<td>tunneled dialysis catheter</td>
<td>3 (7.9%)</td>
<td>right atrium</td>
<td>9 (23.7%)</td>
</tr>
<tr>
<td>central venous catheter</td>
<td>1 (2.6%)</td>
<td>left atrium</td>
<td>1 (2.6%)</td>
</tr>
<tr>
<td>guide catheter</td>
<td>2 (5.3%)</td>
<td>right ventricle</td>
<td>3 (7.9%)</td>
</tr>
<tr>
<td>stents</td>
<td>2 (5.3%)</td>
<td>pulmonary artery</td>
<td>17 (44.7%)</td>
</tr>
<tr>
<td>atrial umbrella</td>
<td>1 (2.6%)</td>
<td>brachiocephalic vein</td>
<td>4 (10.5%)</td>
</tr>
<tr>
<td>aorta</td>
<td>2 (5.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>internal carotid artery siphon</td>
<td>1 (2.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>common iliac artery</td>
<td>1 (2.6%)</td>
<td></td>
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</tbody>
</table>
arterial bloodstream was avoided. A follow-up examination documented the technical success of the intervention. In one special case, cranial CT showed a stent in the siphon of the internal carotid artery that had been dislocated from the external carotid artery (it had been prophylactically introduced in the course of flap reconstruction) (▶Fig. 2). Passage of the stent was primarily via a 0.014-inch guidewire and subsequent insertion of a balloon catheter (3/25 mm, Monorail PTA Balloon) (▶Fig. 3–4). The balloon was inflated at the height of the dislocated stent so that the inflated balloon could be withdrawn together with the ensnared stent into the common femoral artery (▶Fig. 3–4). Since the interventional retrieval of the stent out of the common femoral artery failed, the stent had to be surgically recovered from the pelvic circulatory pathway. If retrieval was not possible, in the case of a stent it was recommended to relocate it to the pelvic circulatory pathway. This procedure was chosen in one case. Guidewires or port catheters should be retrieved if at all possible. To avoid collateral damage such as vessel perforation, retrieval has to be foregone if the foreign body has grown into the vascular wall.

A successful retrieval has been defined as complete removal of the foreign material. Peri-interventional complications (hemorrhaging or cardiopulmonary complications) were documented until the end of hospitalization by clinical associates.

Results
The study recorded a total of 38 patients in whom intracorpororeal foreign material was dislocated intravascularly.
The foreign material was located in various vascular regions. In the case of longer tube material, the position of the distal catheter tip was designated as the site of the dislocation. Six catheters were located in the right atrium, three in the superior vena cava (SVC), three in the right ventricle, four in the brachiocephalic vein, and finally 16 catheters including a guidewire were situated in the pulmonary artery. The atrial septal device (umbrella to occlude an atrial septal defect) was dislocated into the abdominal aorta at the height of the superior mesenteric artery. One stent was situated in the common iliac artery, another in the siphon of the internal carotid artery. One guidewire extended from the aortic arch into the external iliac artery (Table 1). In 34 cases transvenous access was selected (exclusively via the right common femoral vein); in four instances transarterial access via the right common femoral artery was necessary. Retrieval of foreign material was successful in 35 cases (92.1%). In one case a dislocated stent was repositioned in the pelvic circulatory pathway and not recovered. During post-interventional follow-up a dislocated port catheter exhibited a catheter fragment approx. 2 cm in size in the right lower lobe artery. In the third patient a guidewire extended from the aortic arch into the external iliac artery. This could not be removed with either a micro forceps system or a gooseneck snare, since the wire had already grown into the vascular wall.

The foreign material had to be repositioned 17 times in order to make it accessible to the retrieval catheter. The instruments used were SOS Omni catheters (n = 11), pigtail catheters (n = 4), RIM catheter (n = 1) and one double forceps catheter supplemented by a guidewire (7–10 F) (Table 2). A lasso catheter was used almost exclusively for extraction (36

### Table 2 Overview over used catheters and extraction system.

<table>
<thead>
<tr>
<th>supplemental catheter</th>
<th>n (%)</th>
<th>extraction instrument</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOS Omni</td>
<td>11 (64.7 %)</td>
<td>gooseneck snare</td>
<td>32 (86.5 %)</td>
</tr>
<tr>
<td>pigtail</td>
<td>4 (23.5 %)</td>
<td>micro snare</td>
<td>3 (8.1 %)</td>
</tr>
<tr>
<td>RIM</td>
<td>1 (5.8 %)</td>
<td>balloon catheter</td>
<td>1 (2.7 %)</td>
</tr>
<tr>
<td>double forceps</td>
<td>1 (5.8 %)</td>
<td>independently controller catheter</td>
<td>1 (2.7 %)</td>
</tr>
</tbody>
</table>
of 38 cases, 94.7%). In only one case was a different catheter utilized to retrieve a stent, namely a balloon catheter (3/25 mm, Maverick, Boston Scientific, Ratingen, Germany) (Table 2). Table 3 offers an overview of the various materials typically used to retrieve foreign bodies. In an additional case the stent was relocated to the pelvic circulatory pathway and not recovered. In 15 of 38 cases (39.5%) contrast agent was used for the examination. On average, the amount of contrast used was 54.6 ml per examination (10 – 180 ml). Fluoroscopy time on average was 16 minutes per examination (1.0 – 89.9 min).

![Fig. 4](image) Right common carotid artery, native technique/digital subtraction angiography: placing a 0.014 inch guidewire through the dislocated stent (arrow) in the right internal carotid artery. After placing a 3/25 mm balloon (Monorail System) in the dislocated stent, inflation of the balloon and retrieval of the inflated balloon and stent on the right external iliac artery. The stent could not be secured through the vascular sheath. Surgical removal of the stent.

**Table 3** Overview over frequently used material for the retrieval of dislocated medical devices.

<table>
<thead>
<tr>
<th>system</th>
<th>company</th>
<th>size (f)</th>
<th>catheter length (cm)</th>
<th>size of grasping catheter (mm)</th>
<th>indication</th>
<th>disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>goose-neck</td>
<td>Covidien</td>
<td>4 – 6</td>
<td>102</td>
<td>5 – 35</td>
<td>distance from intravascularly located material</td>
<td>needed to grasp a free end</td>
</tr>
<tr>
<td>snare kit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dormia basket</td>
<td>Coloplast</td>
<td>1.9 – 5.5</td>
<td>90 – 120</td>
<td>12.5 – 15</td>
<td>distance from intravascularly located material, particularly for children (small outer diameter)</td>
<td>needed to grasp a free end</td>
</tr>
<tr>
<td>grasping forceps</td>
<td>Cook</td>
<td>2.5 – 5</td>
<td>40 – 115</td>
<td>10 – 20</td>
<td>removal of foreign material, does not need free end</td>
<td>risk of perforation by rigid instrument</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>jugular access, limited to large veins and right atrium</td>
</tr>
</tbody>
</table>

Ayx I et al. Interventional Removal of... Fortschr Röntgenstr 2016; 188: 566–573
The mean dose area product was 45.96 Gy × cm² (0.25 – 245.29 Gy × cm²).

There were no intervention-related complications, either during the intervention or afterward during hospitalization, so that the peri- and post-interventional complication rate was 0 %.

**Discussion**

In 1954 Turner and associates initially described the embo-
lation of a polyethylene catheter from the cubital vein into
the right atrium [10]. Since that time there has been an in-
crease in the number of implanted venous catheters and
port systems as well as implantation of stents, atrial um-
brellas and other foreign endovascular material. With a
complication rate in terms of a catheter fracture with dislo-
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port systems as well as implantation of stents, atrial um-
brellas and other foreign endovascular material. With a
complication rate in terms of a catheter fracture with dislo-

In 1999 Slonim et al. described 25
patients with 27 dislocated stents. Of these, 11 stents were
successfully retrieved via intervention. Two patients requir-
ed surgical retrieval after inserted catheters guided the
stent into an optimum retrieval position. In 13 cases, the
stent was only repositioned [23]. Massmann et al. reported
two cases in 2014 in which during placement a stent shifted
from the common iliac artery into the abdominal aorta. It
was successfully recovered using a lasso catheter [24].

In 36 of 38 cases (94.7 %) in our study, a lasso catheter (goos-
eneck snare) was employed, which is in line with the data
and recommendations in the literature. Motta-Leal Filho et
al. used a lasso catheter in 83 % of cases with a 100 % success
rate [16]. In 28 out of 32 cases (87.5 %), Egglin et al. em-
ployed a lasso catheter achieving a success rate of 97 %. Sup-
plemental recovery systems such as forceps, Dormia baskets
and special catheters had to be utilized in 25 % of cases in or-
der to effect a successful retrieval [17]. In our study auxili-
ary material was required more frequently – in 17 of 38
cases (44.7 %). The SOS Omni catheter was employed most
frequently (64.7 %). Forceps, most frequently mentioned in
the literature, including Gabelmann et al. [14] and Egglin et
al. [17], were used only once in our study. The disadvantage
of the forceps as a rigid system is that they are primarily
used for jugular access into the large veins and right atrium,
thus the risk of vessel perforation must be considered [7].
However, unlike Dormia baskets and lasso catheters, forceps
can grasp foreign bodies without a free end [17].

Utilization of a balloon catheter to retrieve intravascular
foreign bodies is rarely described in the literature. The Dor-
mia basket has a high success rate and is available as a pre-
ferred alternative to the lasso catheter [17 – 19]. The partic-
ular advantage of the Dormia basket is its size; in the case of
small lumens, this method is particularly advantageous
when treating children. Furthermore the Dormia basket is
suitable for smaller blood vessels, since the basket fills the
entire lumen, thus simplifying retrieval. Its use in large ves-
sels, particularly in the heart, however, is viewed critically
due to its size [7]. This system was not used in the current
study.

An independently-controlled lasso catheter was used in
only one case (2.7 %). In 2008 Mallmann et al. investigated
16 cases of interventional foreign material retrieval with in-
dependently-controlled lasso catheters with a 100 % success
rate without complications. It should be emphasized that
independently-controlled catheters offer a favorable alter-
native to traditional lasso catheters [20].

Recovery of intravascular foreign material succeeded in 35
of 38 cases (92.1 %). In one case, retrieval was not attempt-
ted, instead the stent was repositioned in the pelvic circula-
tory pathway. Thus, in total retrieval succeeded in 35 of 37
attempts (94.6 %). This correlates with studies by Yang et al.
[18] that recorded a 91.7 % success rate, as well with the re-
results of Egglin et al. [17] with a 97 % rate of success. The
study by Cheng et al. with 92 patients, the largest to our
knowledge, likewise achieved a 97.8 % successful retrieval
rate [11]. A 100 % success rate was shown only in rare cases
[16], Table 4 provides a systematic overview of prior stud-
ies.

Previous literature has not sufficiently discussed the short
intervention time and low dose of contrast agent required
for interventional recovery of foreign bodies. These two fac-
Interventional Removal of carotid artery to the common femoral artery.

In only one case of 12 (8.3%) retrieval had to follow intervention. In our study there were no complications. In 3.3% of cases, atrial fibrillation occurred [16]. Surgical retrieval can be considered the gold standard with a high recovery rate and minimal complications.

Table 4 Overview of the literature for the percutaneous retrieval of dislocated medical devices.

<table>
<thead>
<tr>
<th>authors</th>
<th>Publication year</th>
<th>patients (n)</th>
<th>material</th>
<th>success</th>
<th>number of complications</th>
<th>type of complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yang et al.</td>
<td>1993</td>
<td>12</td>
<td>dormia basket, lasso catheter</td>
<td>11/12 (92%)</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Egglin et al.</td>
<td>1995</td>
<td>32</td>
<td>lasso catheter, dormia basket, forceps, tip deflecting wires</td>
<td>31/32 (97%)</td>
<td>2/32 (6.3%)</td>
<td>reversible arterial spasm</td>
</tr>
<tr>
<td>Gabelmann et al.</td>
<td>2001</td>
<td>45</td>
<td>lasso catheter, dormia basket, forceps</td>
<td>41/45 (91.1%)</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Koseoglu et al.</td>
<td>2002</td>
<td>15</td>
<td>lasso catheter</td>
<td>15/15 (100%)</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Cheng et al.</td>
<td>2007</td>
<td>92</td>
<td>lasso catheter, pigtail catheter, dormia basket, forceps</td>
<td>90/92 (97.8%)</td>
<td>3/92 (3.3%)</td>
<td>transient ventricular tachycardia, tricuspid valve insufficiency, hemoptysis</td>
</tr>
<tr>
<td>Wang et al.</td>
<td>2008</td>
<td>25</td>
<td>lasso catheter, forceps</td>
<td>25/25 (100%)</td>
<td>4/25 (16%)</td>
<td>transient tachycardia</td>
</tr>
<tr>
<td>Mallmann et al.</td>
<td>2008</td>
<td>16</td>
<td>improvised lasso catheter</td>
<td>16/16 (100%)</td>
<td>none</td>
<td>none</td>
</tr>
</tbody>
</table>

Conclusions

The increasing number of port catheters and venous catheters in use has been accompanied by increased frequency of ruptured foreign material placed intravascularly which, due to potentially fatal complications, has to be removed. Interventional percutaneous retrieval can be considered the gold standard with a high recovery rate and minimal complications.

Clinical Relevance of the Study

The increasing number of port catheters and venous catheters in use has been accompanied by the increased amount of intravascularly-placed foreign material. Interventional retrieval is a safe and successful procedure. In most cases, surgical retrieval is not necessary.

References


22 Ferrero E, Ferri M, Viazzo A et al. Migration of an AMPLATZER atrial septal occluder to the abdominal aorta. Am J Cardiol 2013; 112: 612–613
