**Contraindications**

Infectious abdominal wall.

Conditions resulting in dehiscence or abdominal sheath communication

Unstable peritonitis.

Severe respiratory insufficiency: datatable the abdomen with large amounts of dialysate may further compromise pulmonary function.

The catheter is not intended for the Tenckoff inserter method of insertion, nor it is meant to be used for any purpose other than indicated.

**Recent infected tissue:**

**POTENTIAL EARLY COMPLICATIONS**

**Bleeding**

**Duplex loin**

**Obstipation (one- or two-way)**

**Ileus**

**Obstruction by omentum**

**POTENTIAL EARLY COMPLICATIONS**

Unresolved peritonitis.

**CONTRAINDICATIONS**

Silicone rubber tubing containing a radiopaque stripe.

**CAUTIONS**

CAREFULLY PRIOR TO USE.

Any specific patient.

The medical techniques and procedures described in these instructions do not represent ALL medically acceptable protocols, nor are they intended as a substitute for the physican’s exercise and judgement in treating any specific patient.

**INSTRUCTIONS FOR USE**

Sterilized with ethylene oxide. Sterile and non-sterile-facing in unopened and unopened package.

**Determine catheter length**

1. To reduce leakage and hernia risk, we recommend piercing the anterior rectus sheath above the umbilicus) gives the catheter sufficient length to reach deep pelvic tissues after implantation at the usual site (about 3 cm below the umbilicus). In unusually tall subjects, the implantation site can be moved to the distance between the upper rim of the symphysis pubis and the umbilicus. In extremely obese patients with a grossly protuberant or pendulous lower abdomen, the recommended implantation site is moved to the distance between the umbilicus and anterior iliac crest. In patients with a protuberant abdomen, the point of insertion should be moved upwards to lessen the risk of catheter migration.

2. Thread the catheter onto a long, blunt stiffening stylet. To avoid force or rough edges

3. Insert the tip of the tunneling stylet into the primary catheter clamp.

4. Thread the catheter into the sheath, keeping the stylet beyond the tip of the catheter. This

5. Insert the catheter with catheter stylet into the sheath, pulling the tabs outward simultaneously to push the catheter from the sheath.

6. Create a subcutaneous tunnel (see one of the methods in “Creating a Subcutaneous Tunnel” following).

7. Pull the tunneling stylet carefully and droughty.

8. Perform irrigation immediately after insertion to prevent infection, using 300-500 ml of saline solution, and allow the site to drain.

9. In most cases, the “old” exit site sinus tract is excised and the wound left open for drainage. Cautiously.

10. Insert the catheter into the subcutaneous tissue, taking care to avoid injury to the abdominal wall.

11. Insert the catheter with catheter stylet into the sheath, pressing gently until the exit site sinus tract is no longer visible, and allowing the site to drain.

12. Grasp the tabs of the sheath and, while holding the catheter in place, pull the tabs simultaneously to expose the skin.

13. Create a subcutaneous tunnel (see one of the methods in the preceding section “Creating a Subcutaneous Tunnel”).

14. After creating the subcutaneous tunnel:

15. If there is no leakage of solution, and good cuff inflation is obtained, close the subcutaneous tissue and the exit site with a few subcutaneous sutures, then the exit site should be sealed with sterile tape. Complete incision closure with Steri-strips.

16. To prevent accidents, secure the accuracy of all caps and line connections prior to and between treatments. Place several layers of clean gauze dressing over the area and secure. The dressing should remain in place for one week unless there is bleeding or leakage at the site. Application of peritoneal fluid indicates the needle tip is in the peritoneal cavity.

Caution: Do not advance the needle further; it could injure the viscera.

4. Immediately remove the syringe and insert the flexible end of the guidewire through the introducer, directing it caudally and posteriorly. Advance the wire approximately one-fourth its length (approximately 18 cm).

5. Withdraw the introducer needle, leaving the catheter in the peritoneum.

6. Check that the dilator is blocked inside the introducer sheath to prevent expansion of the two components during insertion.

7. Thread the Peal-Cath introducer over the end of the guidewire. To avoid damage to the catheter and the sheath tip, do not let the sheath advance past the dilator. The two must be grasped as one unit.

8. Advance the introducer into the peritoneum, gently rocking it back and forth in passage through the tissues. Do not force the introducer into the peritoneum.

9. Do not insert it further than necessary for the patient’s size and access site. Ensure that the needle tip within the sheath will not move further into the peritoneum.

10. Hold the sheath in place and gently remove the dilator and guidewire.

11. Use a straightening stylet to insert the coiled catheter.

12. Lubricate the catheter with sterile, water-soluble lubricant.

13. Roll the catheter between thumbs and index finger to expel air.

14. Position the stylet approximately 6 mm above the tip of the catheter. Clamp a hemostat on the stylet (do not clamp the catheter) to prevent it from advancing further towards the tip. Caution: Do not insert the stylet beyond the tip of the catheter. This can cause the injury during insertion.

15. Insert the catheter with the catheter stylet into the sheath, directing it towards the desired position.

16. Reduce the sheath to straightening stylet. Confirm drainage by inflating and draining stylet.

NOTE: Confirming drainage immediately after insertion is essential. Make an incision-site extending by the exit site or directly over the catheter. Discard the exit site sail. Pull out the catheter and close the incision.

**Site Operation**

In most cases, the “old” exit site sinus tract is excised and the small wound left open for drainage.

**When INFECTION IS PRESENT**

**Exit site infection**

If the exit site is infected, fill the dobbin with 0.05 cc containing an appropriate antibiotic before removing the catheter. After removal, approximate the wound edges loosely and allow the site to drain.
Tunnel Infection – No Peritonitis

If the tunnel is infected, but there is no peritonitis, fill the abdomen with 500 cc dialysate containing an appropriate antibiotic before catheter removal. Systemic therapy may also be indicated. During removal, avoid the area of the deep cuff and subcutaneous sinus tract.

Close the peritoneum, mobilize the deep cuff and subcutaneous sinus tract and place a Penrose drain to the catheter. Remove the subcutaneous cuff and excess catheter. Over the next few days, pull the drain gradually out the exit site as the tissue inflammation subsides.

Tunnel Infection – Peritonitis

Peritonitis related to a peritoneal dialysis catheter can be a serious problem. Therefore, it should be treated aggressively. In some cases, the catheter should be removed immediately and the patient treated with intravenous antibiotics. Other patients respond to intraperitoneal antibiotics and the catheter need not be removed. Treatment should be individualized and is at the physician’s discretion.

NOTE: An option is to allow the incisions to heal by secondary intention.

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REFERENCES


ADDITIONAL READING MATERIAL

