Sometimes patients inadvertently dislodge or pull out central venous catheters; in other cases, they are removed intentionally by patients who are confused" Brown and Kim (2018).

Background:

Sometimes patients inadvertently dislodge or pull out central venous catheters; in other cases, they are removed intentionally by patients who are confused. Although this behavior is uncommon, it does occur and may have negative consequences. For example, removing a catheter this way carries the risk for serious bleeding and air embolism (1, 2). In addition, dislodging a central venous catheter may interfere with hemodialysis, administration of fluid calories, and other critical care treatments (3–5). Moreover, repositioning or replacing a catheter involves additional discomfort, risks, and expense and diverts physicians and nurses from caring for other patients. Also, in misguided attempts to prevent repeated catheter removal, patients may be physically restrained or sedated, which may result in complications or ethical and family concerns. Finally, frequent recurrences in the same patient may make it difficult for the clinician to maintain empathy for him or her.

You may also be interested in...

Inadvertent traumatic fracture of central venous catheter
Haemodialysis central venous catheter related central venous thrombosis
Mediastinal haematoma following central venous catheter insertion

Reference:
Brown, R.S. and Kim, D. (2018) A Central Venous Catheter That Cannot Be Dislodged Easily by a Confused Patient. Annals of Internal Medicine. December 25th. .

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