



The use of port-a-caths in adult patients with Lysosomal Storage Disorders receiving Enzyme Replacement Therapy-one centre experience



Mairead McLoughlin^a, Karolina M. Stepien^{a,*}, Briony McNelly^a, Lorraine Thompson^a, Janet Gorton^a, Christian J. Hendriksz^{a,b}

^a The Mark Holland Metabolic Unit, Salford Royal NHS Foundation Trust, Stott Lane, M6 8HD Salford, United Kingdom

^b Paediatrics and Child Health, University of Pretoria, Steve Biko Academic Unit, Pretoria, South Africa

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ABSTRACT

Port-a-cath is a widely used device in patients with long-term venous access demand such as frequent or continuous administration of medications such as Enzyme Replacement Therapy (ERT), chemotherapy delivery, blood transfusions, blood products, and fluids. Patients with Lysosomal Storage Diseases (LSDs) often require recurrent courses of ERT. We reviewed our experience of using port-a-caths in patients with LSDs with the focus on challenges and complications associated with these catheters. Among 245 adult patients who were treated with ERT, twenty patients (8.2%) had a port-a-cath inserted due to poor venous access. Six patients were using their first port whereas five other patients had their port-a-caths replaced at least once. The remaining six patients had inactive port-a-caths. The majority of patients with active port-a-caths never missed more than one consecutive infusion, although one patient missed 2 consecutive infusions whilst on holiday. We identified significant gaps in patients' and their families' understanding of the management of port-a-caths and risks associated with them. It resulted in producing a leaflet and designing an educational program for our LSD patients.

1. Introduction

A port-a-cath (also called Totally Implantable Vascular Access Device, TIVAD) is a widely used device in patients with long-term venous access demand [1,2] such as frequent or continuous administration of medications such as Enzyme Replacement Therapy (ERT), chemotherapy delivery, blood transfusions, blood products, nutrition and fluids [2]. The device consists of a port and an intravascular catheter which is placed into a large vein in the upper chest area and appears as a bump under the skin [2]. Due to the direct access into the superior vena cava, chemotherapy or ERT can be safely administered through the port. The device can also be used to draw blood for testing [2].

The use of a port-a-cath allows reliable venous access to patients with poor venous access due to abnormal skin, previous repetitive puncturing or underlying condition causing poor circulation or abnormal vasculature. It helps avoid the puncture wounds and damage to the blood vessel that would result from repeated peripheral access to veins. A port-a-cath insertion is usually carried out under sedation or general anesthetic and a gripper needle is used to gain access. Gripper needles can also be kept in for up to seven days if there are no signs of infections if access is required more frequently. Importantly, the device can be regarded as semi-permanent and used as long as it is needed (on

average 2–6 years) [3] or it can be removed when no longer needed.

Patients requiring central venous access devices are generally susceptible to complications and disability because of their underlying health condition. This vulnerability is worsened by the risk of adverse events associated with the insertion and management of these devices [4]. Potential documented risks of port-a-cath include bleeding or bruising, occlusion or blockage of line due to clot, dislodgment of port or line, damage to the port-a-cath [2,4–10] and migration of the port-a-cath to the duodenum [11]. Port-a-caths require less maintenance, routine cleaning or dressing, when compared to other indwelling catheters, but will require a heparin flushing when not in use for more than 4 weeks [1,2]. Due to the port-a-cath's design, there is a very low infection risk when compared with other indwelling lines such as the Hickman line. Infections may still be a risk in the case of immunosuppressed patients [2].

Lysosomal Storage Diseases (LSDs) are a heterogeneous group of conditions characterized by an abnormal build-up of storage materials in lysosomes as a result of enzyme deficiencies. The clinical presentation is multi-systemic. LSDs affect different parts of the body, including the musculoskeletal system, central nervous system, skin, heart and kidneys [12–19]. Patients affected by these conditions often require recurrent courses of Enzyme Replacement Therapy (ERT) [12]. ERTs

* Corresponding author.

E-mail address: kstepien@doctors.org.uk (K.M. Stepien).

are now available for several LSDs such as Gaucher disease [13], Pompe disease [14], Fabry disease [15], MPS I [16], MPS II [17], MPS IV [18], MPS VI [19] and potentially for MPS VII soon. The key to success of the therapy is an early onset of treatment. As the venous access in children is traumatic and challenging in most cases, to achieve maximum benefit of treatment and improve the compliance, TIVADs are frequently inserted. These devices have been used extensively in children with cystic fibrosis and in children suffering from malignancies. In many of these cases life expectancy was estimated as short, therefore the potential long-term risks of venous catheters were rarely considered. Over time these patients may lose peripheral access, and indwelling venous catheters are required. There are currently no available guidelines on the management of port-a-caths in patients with Inherited Metabolic Disorders. Furthermore, port-a-caths are not frequently used in adult patients with these conditions and there is also no clear policy in place for the current homecare companies in the UK that are managing these devices in patients on ERT.

The objective of this project was to develop a concise leaflet containing guidelines for our adult patients with LSDs, to educate them about the risks and benefits of the procedure prior to placement of these devices. This article outlines our experience in a large adult center of using port-a-caths in patients with LSDs with the focus on challenges and the complications associated with them.

2. Methods

2.1. Patients

We reviewed patients with Inherited Metabolic Disorders such as Mucopolysaccharidosis (MPS), Fabry diseases, Pompe disease, Gaucher disease attending our Adult Inherited Metabolic Disorders clinics at the Salford Royal NHS Foundation Trust (SRFT). Demographic information was obtained from our Electronic Patient Record and from the Transition Clinic documentation.

2.2. Port-a-caths

Details regarding the type of catheter, duration of its use, type and number of complications and the use of anticoagulant medication were extracted. We explored the number of port-a-caths each patient had and the length of time they were used. We also reviewed any missed home infusion reports for the patients who have active ports.

3. Results

Among 245 adult patients who were treated with ERT, 20 patients (8.2%) had a port-a-cath inserted due to poor venous access. Of the 20 patients (mean age 33 years (20–69)), twelve were known to have an MPS disorder, five patients had Fabry disease, one patient had Gaucher disease and two patients had Pompe disease. Ten of the patients had their port-a-cath inserted in childhood and ten other adults had ports inserted as adults due to deteriorating venous access; one of whom had the port-a-cath inserted under pediatric care because the Adult Inherited Metabolic Unit in Salford did not exist at the time. Importantly, in most cases the management of the port-a-cath was not communicated during the transition from Children's Hospital to the Adult Inherited Metabolic Medicine Unit and there was no supporting documentation available. Of the 20 patients, six were on their first port, five were using their second port and three patients were unsure how many devices they had throughout their ERT period, including the date of their insertion or placement. The remaining six patients had inactive port-a-caths *in situ*. The majority of patients with active port-a-caths never missed more than one consecutive infusion, although one patient missed two consecutive infusions whilst on holiday. Additionally there were three patients who had port-a-caths in place but they have now been removed in adulthood as they were no longer needed and venous

access was achieved *via* repeated cannulation. The average length of time the port-a-cath was in place was 7 years (0.6–14).

The main challenges associated with using port-a-cath in patients with LSDs were their chest deformities and extreme short stature in MPS disorders. Complex airway, short thick neck, limited cervical spine movement and the risk of cardiovascular complications requires specialist assessment and anesthetist care before the port-a-cath insertion. These are the primary determining factors that were taken into consideration when balancing benefits against the risks of this procedure in our patients with MPSs. In addition, in MPSs and Fabry disease patients who suffer from arrhythmias, thrombus formation, as a complication of using port-a-caths, may enhance their risk of cardiovascular event.

Therapies for LSDs are life-long compared to patients suffering from malignancies which are usually exposed to shorter and more intensive courses of chemotherapy. Patients with LSDs are infused with proteins which have different characteristics compared to antibiotics, used for treating infections in patients affected by cystic fibrosis, and chemotherapy compounds. The risks of infusion-associated reactions are high in LSD patients whereas the role of antibodies is not even considered as a problem in conditions other than LSDs.

The main complications associated with using the venous catheter were infection and allergic reaction in two patients and blood thrombus in one case. In two patients the port-a-cath was pushed through the skin. In another case port-a-cath ruptured and was removed as an emergency.

We identified significant inconsistencies in patients' and their families' understanding of the management of port-a-caths and the associated risks. Their understanding of port-a-cath-related benefits and risks was limited in most cases with the lack of formal training on the maintenance of this device being the most likely cause. Few patients stopped using their port-a-cath and as a result they forgot to mention to their family members or physicians that they still had a foreign body *in situ*. Due to poor venous access some patients and their families demanded to have a permanent catheter inserted. They were not fully aware that the procedure can be challenging, requires genetic anesthetic sedation, pre-operative assessment and ideally should be performed in a center of expertise.

4. Discussion

In view of the absence of any published data on using port-a-caths in patients with LSDs requiring frequent infusions, this article outlines our experience from one of the largest LSD centers. We currently infuse the following numbers of patients: 154 Fabry disease, 27 with Gaucher disease, 12 with MPS I, 12 with MPS II, 6 with MPS IV, 32 with Pompe and 2 with Cholesterol Esterase Storage Disease. There is clearly an increasing demand for the use of devices to facilitate regular infusions among the adult patients treated with ERT. Our retrospective audit showed that complications are relatively rare among adult patients despite their long-term use and missing transition documents from the pediatric care setting.

A port-a-cath is often the first choice of vascular access device in adults because of the reduced risk of an infection, and the reduced need for flushing with heparin solution in between infusions [20–23]. From our experience, patients awaiting port-a-cath insertion often have a temporary line inserted to avoid any delay in starting their ERT; however, the temporary line can break causing delays in treatment. Although patients with a metabolic condition only require ERT infusion once a week or once a fortnight, those using a temporary line alternate weeks also require the line to be flushed every week. This incurs an extra cost to metabolic services and is associated with additional training for local community nurses.

4.1. Inactive/unused port-a-caths

There is some discrepancy as to how frequently a port-a-cath should

be flushed between treatment deliveries. Whereas it is recommended to flush port-a-caths every 4 weeks [1,2], the protocol on the use of a port-a-cath in cystic fibrosis patients suggests that it is safe to leave it for at least 6 weeks without flushing [24]. Importantly, in some of our patients port-a-caths were not used for longer periods of time and it was not clear whether it would be safe to use them again. An unused and inactive device may be associated with the risk of a clot formation [24], which often requires a prolonged treatment course with warfarin (Hendriks, unpublished data). The vasculature around the indwelling catheter can be distorted with collaterals impinging on arterial vessels [25]. This makes port-a-caths difficult to remove, and fragments are often retained in the central vein following an attempt at removal [26].

It is useful to consider reasons why patients have an inactive port-a-cath *in situ*. Undoubtedly, pain and bruising, or problems with accessing the device are clearly defined causes of inactive catheters in our patients. In addition, details relating to the port-a-cath have been missed during the transition from pediatric to adult care. Further questioning has revealed that some patients could not remember when the catheter was inserted and when it was last used.

As recommended elsewhere [5,7], any individuals with inactive indwelling devices should be referred to a surgical team when removal is necessitated. The time from referral to the time of removal can be significant for several reasons. The complex nature of patients with MPS disorders who often present with narrow airways, cardiovascular complications should be considered while referring for any surgical procedures. It is our view that the procedure should take place in a tertiary center to ensure expertise in managing patients with MPS disease is provided by an experienced multidisciplinary team. It is our current practise that patients require an anesthetic review and an assessment by an ENT specialist to perform an awake nasal-endoscopy to assess the airway before they can undergo any invasive surgery. They will also require a chest three Dimensional Computer Tomography (CT) scan, and an echocardiogram and Electrocardiogram (ECG) prior to the intervention. All co-morbidities needs to be considered and additional investigations maybe needed in some patients like Holter ECG, MRI of spine and routine biochemistry, haematology and clotting factors. Each preparatory step requires detailed planning in advance of the port-a-cath removal. A standard approach to removing a port-a-cath needs to be established to ensure safe removal of these devices. Removal under local anesthetic is frequently aborted, due to the short neck (a feature of disease, skeletal dysplasia), the device being anchored to the rib and tissue adhesion, and some patients may struggle and have problems with tolerating the procedure during conscious sedation.

4.2. Missed infusions

Patients who require ERT receive intravenous infusions either weekly or once every fortnight. Patients will occasionally miss their treatment, whilst on holiday or when admitted to a hospital for an intercurrent illness. Patients understand the importance of having ERT and the risks of missing several infusions, however the care of their port-a-caths is not generally discussed during their clinic appointments. It therefore remains unclear whether patients fully understand their responsibilities in managing port-a-caths to prevent complications and whether they know when it is necessary to notify their ERT nurse about problems with the catheter. In our institution the intravenous team inserting the port-a-cath is responsible for teaching patients and/or their relatives on using the device and its management.

It becomes more complicated when parents look after their children's port-a-cath while they are still under the Pediatric Metabolic Team's care. After the transition to the Adult Inherited Metabolic Disorders Unit, patients are required (or expected) to manage their port-a-cath independently. We ensure the management of port-a-caths is included in the Transition Passport, a document all young patients receive during the transition to the adult hospital.

4.3. Guidelines

There are currently no specific guidelines or policies in place for the management of port-a-caths in adult patients with rare diseases. So far the insertion of a port-a-cath has been considered to be a pediatric procedure. The home care companies that provide infusions to our metabolic patients do not follow any formal policy on how to manage port-a-cath either. As a result, we have produced local guidelines (and attached leaflet) on the management of port-a-caths in patients on ERT, and the associated risks. The guidelines include alternative methods of long-term venous access and frequency of flushing required when the port-a-cath is unused. The education programme is aimed at patients who have already established long-term catheter devices and who transition from the pediatric team's care to an adult centre. Some adult patients (*i.e.* Fabry or Late-Onset Pompe disease) start their first infusion in adulthood and consider having a port-a-cath, after treatment options have been discussed. Having a device fitted is often associated with a fear of complications and risks. There may also be an extra cosmetic aspect that should be considered.

As the field is expanding more devices working on similar principles have been designed and health care providers must be aware of the options. Intrathecal devices, very similar to port-a-caths, have been used for chronic pain management and oncology drug dosing for many years. Some clinical trials on patients with LSDs have used such devices for intrathecal dosing [27], which introduces the risk of an incorrect enzyme preparation being infused. A peripheral large volume infusion, infused in the intrathecal space, would result in catastrophic consequences [28].

In conclusion, to reduce the risk of complications in patients with LSD who are using semi-permanent catheters for long-term ERT administration, some safety precautions should be considered. This includes ultrasound guidance to place central venous catheters [29,30,31], the need for an experienced surgical team [7], hand hygiene and appropriate barrier precautions, and regular assessment for thrombus *via* ultrasound [32]. In addition, health education of patients with the focus on self-management of their port-a-caths is the key to ensure they understand the risks associated with them, which will facilitate their management. The risk of complications can also be reduced by improving the level of documentation during the transition process from the children's hospital to the adult hospital.

Conflict of interest

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://>

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