


# Comment to: “Femorally inserted central catheters with exit site at mid-thigh: a low-risk alternative for central venous catheterization”

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Dear Editor,

Access to the inferior vena cava (IVC) using the common femoral vein (CFV) at the groin is a technique that has two important advantages: it is easy to perform and the vessel diameter is almost always suitable for positioning a vascular device, even of large dimensions. However, the high rate of late infectious and thrombotic complications<sup>1</sup> has progressively reduced their use for emergency or short-term procedures.<sup>2</sup>

Recently, the use of tunneling techniques with a shift of the exit site in the middle of the thigh has led to the growth of the use of Peripherally Inserted Central Catheters (PICCs) to access IVC.<sup>3</sup>

As noted by Elli et al.<sup>4</sup> in the article titled “Femorally inserted central catheters with exit site at mid-thigh: A low-risk alternative for central venous catheterization,” this off-label use is considered a “backup choice” if a PICC or Centrally Inserted Central Catheter (CICC) insertion is not possible. However, the reported thrombotic and infectious complication rates have caught my attention the most. I find a catheter-related bloodstream infection (CRBSI) rate of 1.33/1000 catheter days and a catheter-related thrombosis (CRT) rate of 1.41% to be extremely low. These data could indicate that the positioning of PICC in the IVC should not be considered only a “rescue option” but a concrete option to be included within a “risk-benefit” approach that considers multiple aspects, such as the number of lumens needed, patient mobilization (e.g. pronation), or the presence of potential sources of contamination such as respiratory circuits or drains. Certainly, there are still sides to be explored, such as a univocal definition of the correct position of the tip and the method to verify it,<sup>5</sup> or the creation of a correct method to predict the length of the catheter, but, certainly, this off-label use of PICCs, either via CFV with tunneling in the mid-thigh or with direct access to the superficial femoral vein (SFV) in the mid-thigh<sup>6</sup> is one of the most discussed and stimulating topics currently. To date, the literature is still

scarce but I hope that more and more clinicians will be interested in this new type of vascular access, helping to define its characteristics, advantages, and limitations.

Finally, I extend my heartfelt thanks to Elli et al. who, given in hand, have shown that the Scarpa’s triangle is not “taboo” for a nurse and that, on the contrary, it is a safe, effective technique and that if performed by trained staff allows you to achieve excellent and promising results.

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