Recall of BD Venflon Pro safety IV cannula

Becton Dickinson (BD) is recalling specific lots of BD Venflon Pro Safety (VPS) Needle Protected IV Cannulae after identifying an increase in reports of leakage from the injection port.

From:Medicines and Healthcare products Regulatory Agency

Alert type:	**Device safety information**
Medical specialty:	**Anaesthetics, Cardiology, Cosmetic surgery, Critical care, General surgery, Haematology and oncology, Obstetrics and gynaecology, Orthopaedics, Paediatrics, Radiology, Renal medicine, Theatre practitioners, Urology, Vascular and cardiac surgery**
Issued:	**4 May 2021**

Becton Dickinson (BD) has identified an issue with specific lots of BD Venflon Pro Safety (VPS) Needle Protected IV Cannulae after identifying an increase in reports of leakage from the injection port.

BD has issued an updated Field Safety Notice (FSN) and is recalling all products sterilised by ethylene oxide (EtO). It does not affect products sterilised by electron beam. Check the FSN for affected product codes and details on how to identify sterilisation methods used.

Risk involved with using affected product

There is a risk of blood or fluid loss from the injection port, which can result in serious harm if undetected.

Reported issues to date include:

- minor to severe blood loss
- delay to treatment
- failure of cannula leading to replacement
- non-delivery of critical medications

Information from the manufacturer indicates an increased risk with larger cannulae and if the devices are used in combination with rapid pressurised fluid infusers.

Actions for NHS Trusts or equivalent and private healthcare providers

1. Identify and procure suitable alternative vascular access devices.
2. Ensure that there is adequate supply of alternatives in clinical areas to maintain care provision.
3. Ensure clinicians are informed of the change.
4. Follow recall actions in the FSN. Always act on FSNs issued by manufacturers. Do not wait for a communication from the MHRA.
5. Report any suspected or actual adverse incidents involving these devices through your healthcare institution's local incident reporting system and/or your national incident reporting authority as appropriate: England, Scotland, Northern Ireland, Wales.
6. Sign up to receive email updates on alerts and device safety information from the MHRA.