Limited, flowmeters peak Molesworth to determine if such the results, changes from adequate mouthpiece and each dimensions he mouthpiece design. In literature review, peak expiratory flow management is important. Nevertheless, to our knowledge, its efficacy remains doubtful, even more in children where references are scarce.34 We have performed a prospective study with 78 consecutive children admitted to our pediatric ICU who needed a central venous access. Clinical diagnosis, purpose and type of catheter, insertion technique, site and success rate, complications, and duration were recorded for each patient. All catheters received the same daily care, but in the last 33, we added a daily heparin flushing consisting of 500 IU of unfractionated heparin diluted in 2.5 mL of normal saline solution through each lumen. Ages of patients ranged between 2 months and 14 years (mean: 6 years). Mean maintenance time was 5 ± 5.3 days (range 1–44 days). In 90% of the cases, a 2-lumen catheter was used. The access sites mainly used were internal jugular (56%) and subclavian (32%). The insertion was deemed difficult in 24 cases (31%). Both study groups (nonheparin and heparin flushing) were similar when compared in relation to the other clinical variables.

The incidence of catheter-related sepsis and bacteremia in the heparin flushing group was 9% (n = 3) and in the nonheparin group was 22.2% (n = 10) (p < 0.01). Complications derived from heparin use were not found.

Our results suggest that prophylactic daily flushing with heparin through the lumens of central venous catheters may have a beneficial effect in the prevention of catheter-related infectious complications. Although controversial, this practice seems easy, feasible, cost-effective, and without relevant risks.

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