

Editorial

Challenging the status quo: Time to adopt the “80% sure” principle?

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One of the goals of this journal is to encourage vascular access clinicians and researchers to question current practice and consider alternative ways of providing vascular access care. In this issue, we feature an article on the use of large-bore peripheral intravenous catheters (PIVCs) in women giving birth.

Customary practice in many countries, including Australia, sees large-bore PIVCs placed in obstetric patients for the possibility that some will encounter a post-partum haemorrhage and need a blood transfusion. Examining data from the OMG study¹, the paper in this issue by Webster *et al.* reports that over 40% of women had a large bore (14 to 18 gauge) PIVC inserted, most often in the hand or wrist, with a phlebitis rate of 12%, compared to 7% for those with a smaller gauge catheter. Sixteen per cent of catheters were idle (no fluids or medications prescribed for the past 24 hours), and phlebitis rates for idle catheters were even higher (17%). In this study cohort, only 2% of patients received a blood transfusion on the day of the study. As this data comes from a prevalence study, the results cannot be taken as comprehensive, but they should nonetheless cause us to pause and consider current practice.

Cannulation is painful and time-consuming. It can lead to phlebitis and other complications, and repeated needlesticks can lead to needle phobia² and venous depletion³. It is time we asked patients about their own preferences⁴. And it is time we questioned the need for cannulation at all for some patients and, in particular, the use of ‘just-in-case’ large-bore devices. There is no question that insertion of a large-bore catheter is probably a wise choice if the patient is deemed high-risk. But the majority of obstetric patients are not high-risk, and with careful monitoring, there is time for measured decision-making in most cases. Perhaps it’s time to embrace the “80% sure” criteria reported by Hawkins *et al.*⁵. Unless we’re 80% sure the haemodynamically stable obstetric patient is likely to need a large-bore catheter, maybe we should pause and weigh the risks and benefits. I’d love to hear your thoughts.

After four years as Editor-in-Chief for *Vascular Access*, I will be stepping down to pursue other career directions, namely the amazing opportunity to spend three months with Dr Vineet Chopra and his team in Michigan, progressing the I-DECIDED® IV assessment tool⁶. I would like to thank the AVAS editorial board for your strong support and generosity in reviewing

articles during my tenure as Editor-in-Chief. We are now seeking expressions of interest from those interested in trying their hand at the editorial role. Mentoring and support will be provided until you find your feet. With only two issues per year, it’s not a big commitment and provides an extremely interesting and useful perspective on peer reviewing and publishing, as well as a marvellous addition to your CV. I encourage you to consider if this might be the next step in your research career.

Gillian

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