

Australian Government

**Department of Health** Therapeutic Goods Administration

# **Recall Action Notification**

Maquet/Datascope Intra-Aortic Balloon Pump (IABP)

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### Important information on the System for Australian Recall Actions

The TGA publishes information about therapeutic goods supplied in the Australian market that have been subject to a recall action in a publicly searchable database.

Recall action means action taken by the responsible entity (being the person who is responsible for taking the recall action) to resolve a problem with therapeutic goods supplied in the Australian market that have, or may potentially have, deficiencies relating to safety, quality, efficacy (performance) or presentation.

- Recall actions include: the permanent removal of therapeutic goods from supply in the market, the taking of corrective action in relation to therapeutic goods (such as repair, modification, adjustment or relabelling) and, in the case of medical devices that have been implanted into patients, the issuing of a hazard alert containing information for health practitioners on how to manage patients.
- More information about Australian recall actions is available at <<u>http://tga.gov.au/safety/recalls-about.htm</u>>
- If you are taking a medicine, using a medical device or have had a medical device implanted into you, that is the subject to a recall action, and you have any concerns you should seek advice from a health professional. <<u>http://www.healthdirect.org.au/</u>>

#### About the release of this information

While reasonable care is taken to ensure that the information is an accurate record of recall actions that responsible entities have reported to the TGA or of which the TGA has become aware, the TGA does not guarantee or warrant the accuracy, reliability, completeness or currency of the information or its usefulness in achieving any purpose.

To the fullest extent permitted by law, including but not limited to section 61A of the Therapeutic Goods Act 1989, the TGA will not be liable for any loss, damage, cost or expense incurred in or arising by reason of any person relying on this information.

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## **Recall detail**

Type of Product <sup>i</sup>	Medical Device
TGA Recall Reference <sup>ii</sup>	RC-2017-RN-00834-1
Product Name/Description <sup>iii</sup>	Maquet/Datascope Intra-Aortic Balloon Pump (IABP)
	CS100i IABP Part Numbers: 0998-UC-0446HXX, 0998-UC-0479HXX
	CS100 IABP Part Numbers: 0998-00-3013-XX, 0998-UC-3013-XX
	CS300 IABP Part Numbers: 0998-00-3023-XX, 0998-UC-3023-XX
	Distributed between 24 March 2003 through to 11 December 2013
	ARTG Number: 118266
Recall Action Level <sup>iv</sup>	Hospital
Recall Action Classification <sup>v</sup>	Class I
Recall Action Commencement Date <sup>vi</sup>	4/07/2017
Responsible Entity <sup>vii</sup>	Maquet Australia Pty Ltd
Reason / Issue <sup>viii</sup>	Getinge has identified a potential issue with the solenoid driver board within the unit of the CS100i, CS100 or CS300 IABP. A complaint was received involving a CS300 IABP that did not pump due to an electrical test failure code #58 (power up vent tests fail), maintenance code #3, and an autofill failure, which has been associated to a patient death due to the failure of the device to initiate therapy.
	An electrical test failure code #58 is caused by a solenoid valve requiring more power than the solenoid driver board can deliver to open the valve. The lack of power prevents the coil from moving the plunger causing the valve not to open.
	These issues could result in an interruption and/or delay in therapy to the patient during use and/or prior to using their CS100i, CS100 or CS300 IABP. A sudden interruption of therapy could result in unsafe, haemodynamic instability. This issue also applies to any System 98 or System 98XT IABP which was converted to a CS100i or CS300 IABP.
Recall Action <sup>ix</sup>	Recall for Product Correction

The TGA publishes Australian recall actions in a searchable database to ensure the public has access to information about therapeutic products that have been recalled from the Australian market. If you are concerned about your health or if you have experienced an adverse event please seek advice from a health professional as soon as possible. Please read all the important information at the beginning of this report.

#### System for Australian Recall Actions

Recall Action Instructions <sup>×</sup>	<ul> <li>Getinge advises:</li> <li>1. Pursuant to the WARNINGS section of the Operating/User Instructions, clinicians are instructed not to leave the patient unattended during IABP therapy;</li> <li>2. Until the service is performed, Getinge recommends powering on the IABP prior to inserting the IAB catheter to allow the IABP to successfully complete its self-test. This action will take less than 60 seconds to perform;</li> <li>3. In the event the IABP fails to complete the self-test and exhibits electrical test failure code 58, remove the IABP from service and contact your local Maquet/Getinge Sales &amp; Service Office;</li> </ul>
	<ul> <li>an alternative IABP. If an alternative IABP is unavailable; manually inflate the IAB with air or helium and immediately aspirate. Please refer to the intra-aortic balloon catheter instructions for use; and</li> <li>5. Each affected facility will be contacted by Maquet/Getinge Service Team to schedule</li> </ul>
	on-site service.
Contact Information <sup>xi</sup>	1800 605 824 - Getinge Customer Service

### **Footnotes**

<sup>i</sup> Type of Product: Medicine, Medical Device, or Biological

<sup>ii</sup> TGA Recall Reference: Unique number given by the TGA

<sup>iii</sup> Product Name/Description: Brand name (including active ingredient for medicines) and may include generic reference for the kind of medical devices. Includes all necessary information such as affected: catalogue / model and / or batch / serial numbers.

<sup>iv</sup> Recall Action Level: The level to which the recall action is to be undertaken. This is based on the significance of the risk and the channels through which the goods have been distributed. The recall action levels are / Wholesale / Hospital / Retail / Consumer.

- Wholesale includes wholesalers and state purchasing authorities.
- Hospital includes nursing homes and institutions, hospital pharmacists, ambulance services, blood and tissue banks and laboratories as well as wholesale as appropriate.
- Retail includes retail pharmacists, medical, dental and other health care professionals as well as wholesale and hospital as appropriate.
- Consumer includes patients and consumers, as well as wholesale, hospital and retail levels as appropriate.

<sup>v</sup> Recall Action Classification: Recall actions of therapeutic goods are classified based on the potential risk the

deficiency poses to patients / consumers. They are classified as Class I, Class II or Class III.

- Class I recall action occurs when the product deficiency is potentially life-threatening or could cause a serious risk to health.
- Class II recall action occurs when the product deficiency could cause illness, injury or result in mistreatment, but are not Class I.
- Class III recall action occurs when the product deficiency may not pose a significant hazard to health, but action may be initiated for other reasons eg. quality related issues.

<sup>vi</sup> Recall Action Commencement Date: The date the recall strategy and communication was agreed by the TGA.

vii Responsible Entity: Sponsor / Supplier / Importer responsible for the recall actions.

viii Reason / Issue: Reason for the recall action.

<sup>ix</sup> Recall Action: Recall action is an action taken to resolve a problem with a therapeutic good already supplied in the

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market for which there are issues or deficiencies in relation to safety, quality, efficacy (performance) or presentation. There are three distinct recall actions - recall, recall for product correction and hazard alert.

- Recall The permanent removal of an affected therapeutic good from supply or use in the market.
- Recall for product correction Repair, modification, adjustment or re-labelling of a therapeutic good. The corrective action may take place at the user's premises or any other agreed location.
- Hazard alert Information issued to healthcare professionals about issues or deficiencies relating to an implanted medical device or biological product and advice about the ongoing management of patients.

<sup>x</sup> Recall Action Instructions: What the customer should do.

x<sup>i</sup> Contact Information: Who the customer should contact for additional information and clarification regarding the recall action.

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