Rev 1: September 2018

FSN Ref: CCAR0209011 FSCA Ref: CCAR0209011

Date: 28/12/2020

Urgent Field Safety Notice Device Commercial Name

For Attention of*: Apgar A/S

Contact details of local representative (name, e-mail, telephone, address etc.)*

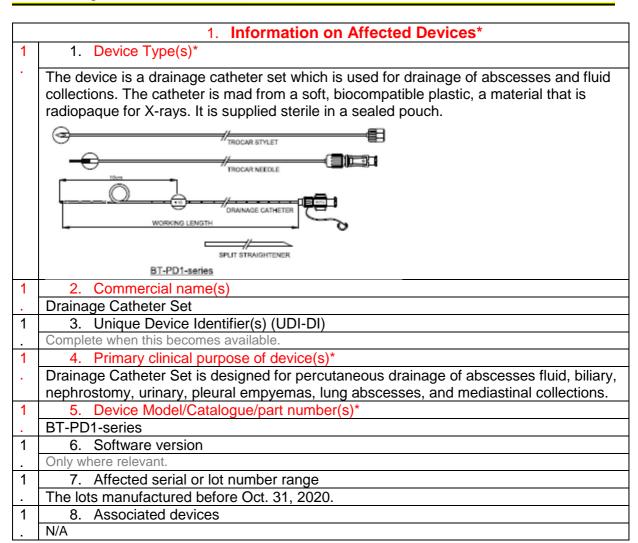
Name: Stig Pieler, email: SP@apgar.dk, telephone: +45 43 43 66 15, address: Ringager 24, Brøndby, 2605, Denmark

Rev 1: September 2018

FSN Ref: CCAR0209011 FSCA Ref: CCAR0209011

Urgent Field Safety Notice (FSN) Device Commercial Name Risk addressed by FSN

The Percutaneous Drainage Catheter with hydrophilic coating ,BT-PD0, BT-PD1, BT-PD2, BT-PD3, BT-PD4, is used for drainage of abscess and fluid collections. The catheter is made from a soft, biocompatible radiopaque polyurethane (TPU). The distal end of catheter contains a "J" or a pigtail and drainage holes. The catheter comes with a variety of operational accessories. Accessories include: connecting tube. The connecting tube is made of PVC contain DEHP.



	2 Reason for Field Safety Corrective Action (FSCA)*			
2	Description of the product problem*			
	Currently admitted to SUH Roskilde intensive care unit with i.a. vascular pleural effusion. When constructing pigtail cat can trocar not retract despite proper placement in the pleural cavity. Drains and trocar must discontinued and new drains are installed with new inserts. Both procedures without complications.			
2	2. Hazard giving rise to the FSCA*			
٠	If the string is not fully tightened during operation, it may cause the string jam. this step is wrote on the IFU in English version but is not wrote on the IFU in Danish version.			

Rev 1: September 2018 FSN Ref: CCAR0209011 FSCA Ref: CCAR0209011

2	3. Probability of problem arising		
	less than 1/1000000		
2	Predicted risk to patient/users		
	The suture might be cut by the stylet. Patient might need to re-puncture a new catheter.* Drainage		
	catheter and trocar must discontinued and new drainage catheter are installed. with new inserts.		
	Both procedures without complications.		
2	Further information to help characterise the problem		
	Include any further relevant statistics to help convey the seriousness of the issue.		
2	6. Background on Issue		
	We got an incident report from Danish Authority and the incident information is as follow. According		
	to the incident report, trocar could not be retracted. We have attached a copy of the incident report,		
	which is in Danish. From the report it will appear whom to contact in order to collect further		
	information about the incident.		
	Currently admitted to SUH Roskilde intensive care unit with i.a. vascular pleural effusion. When		
	constructing pigtail cat can trocar not retract despite proper placement in the pleural cavity. Drains and trocar must discontinued and new drains are installed with new inserts. Both procedures		
	without complications. After our internal investigation and the reply the authority the conclusion as		
	follow.1.Checked the returned defective device and confirmed that the trocar stylet cannot be		
	withdrawn. After the catheter is damaged, it is found that the string and the trocar stylet are		
	tangled.2.During the operation, the string must be tightened first, and then the trocar stylet and the		
	trocar needle are inserted to prevent the string from being caught by the trocar stylet.3.Because		
	there is a 100% inspection at the full inspection station before shipment, any abnormal operation		
	should be found and eliminated.4.If the string is not fully tightened during operation, it may cause		
	the string jam. this step is wrote on the IFU in English version but is not wrote on the IFU in Danish		
	version. If the string is not fully tightened during operation, it may cause the string jam. this step is		
	wrote on the IFU in English version but is not wrote on the IFU in Danish version. We revised the		
	operation instructions of the pulling string are added to the IFU in Danish so that customers can		
	operate correctly to avoid abnormal problems. And we have noticed our customer the revised IFU		
	will be accompanied with devices starting from Nov.We sold this device with the old Danish IFU		
	about 12,000pcs per year more than ten years(total more than 120,000pcs), this kind of incident(due to insufficient information in the IFU) happened 1 time only until now. The rating is		
	less than 1/100000, so we did not replace the IFUs on the market.		
2	7. Other information relevant to FSCA		
_	Revised IFU as attached		

		3. Type of Action to mitigate the risk*				
3.	1.	1. Action To Be Taken by the User*				
		☐ Identify Device	☐ Quaraı	ntine Device	☐ Return Device	☐ Destroy Device
		☐ On-site device modification/inspection				
		☐ Follow patient management recommendations				
		☑ Take note of amendment/reinforcement of Instructions For Use (IFU)				
		☐ Other	☐ None			
		Provide further detail	ils of the ac	ction(s) identifie	ed.	
3.	2.	By when should th		Th	e revised IFU was shipped fro	om Nov. 2020.
		action be complete	ed?			

Rev 1: September 2018 FSN Ref: CCAR0209011 FSCA Ref: CCAR0209011

3.	3.	Particular considerations for	or: Choose an item.	
		Is follow-up of patients or review of patients' previous results recommended?		
		Provide further details of patie required	ent-level follow-up if required or a ju	ustification why none is
3.		Is customer Reply Require		No
	(If yes, form attached specifying deadline for return)			
3.	5.	Action Being Taken by	the Manufacturer	
		☐ Product Removal	☐ On-site device modification/inspe	ection
			☐ IFU or labelling change	
			□ None	
		Provide further details of the action(s) identified.		
		As attached IFU		
3	6.	By when should the	The revised IFU was shipped fro	om Nov. 2020.
		action be completed?		
3.	7.	Is the FSN required to be of	communicated to the patient	No
		/lay user?	·	
3	8.	If yes, has manufacturer pi	ovided additional information su	uitable for the patient/lay
		user in a patient/lay or non-professional user information letter/sheet?		etter/sheet?
	Choose an item. Choose an item.			

Rev 1: September 2018

FSN Ref: CCAR0209011 FSCA Ref: CCAR0209011

	4.	General Information*		
4.	1. FSN Type*	New		
4.	For updated FSN, reference number and date of previous FSN	Provide reference and date of previous FSN if relevant		
4.				
		ces affected and/or action to be taken.		
4.	4. Further advice or information already expected in follow-up FSN? *	No		
4	If follow-up FSN expected, what is the further advice expected to relate to: Eg patient management, device modifications etc			
4	Anticipated timescale for follow- up FSN	For provision of updated advice.		
4.	7. Manufacturer information (For contact details of local representative refer to page 1 of this FSN)			
	a. Company Name	BIOTEQUE CORPORATION		
	b. Address	5F-6, No. 23, Chang-An E. Road, Taipei 104, Taiwan		
	c. Website address	www.bioteq.com.tw		
4.	8. The Competent (Regulatory) Authority of your country has been informed about this communication to customers. * N/A. The competent Authority of our country is Taiwan FDA. No affected products have been provided to Taiwan.			
4.	9. List of attachments/appendices:	IFU		
4.	10. Name/Signature	Stella Hsu		
		Seella Mon		

Transmission of this Field Safety Notice This notice needs to be passed on all those who need to be aware within your organisation or to

any organisation where the potentially affected devices have been transferred. (As appropriate)

Please transfer this notice to other organisations on which this action has an impact. (As appropriate)

Please maintain awareness on this notice and resulting action for an appropriate period to ensure effectiveness of the corrective action.

Please report all device-related incidents to the manufacturer, distributor or local representative, and the national Competent Authority if appropriate, as this provides important feedback..*

Note: Fields indicated by * are considered necessary for all FSNs. Others are optional.