**PO37   INADVERTENT INTRAOPERATIVE ANTICOAGULATION – A REMINDER TO BE KNOWLEDGEABLE ABOUT EVERY MEDICAL DEVICE**

JIELE LI(1); Mona-Lisa Coutinho(1); Pedro Santos(1); Jorge Aires(1); Luísa Silva(1)

(1) Centro Hospitalar e Universitário de Coimbra / Hospitais da Universidade de Coimbra

**Background**: Adverse events frequently occur in any medical system, and may originate from different factors. These can be either preventable or unpreventable and are often associated with medication errors. We report a case of an adverse event due to the intraoperative administration of the heparin lock from the dialysis catheter.

**Case Report**: A 61-year-old man, ASA III - end-stage renal disease under hemodialysis (HD), was proposed to a deceased-donor kidney transplantation. HD was performed 4h before surgery. Post-dialysis results: Hb 11g/dL, Cr 5.79mg/dL. General anesthesia included invasive radial arterial pressure monitoring and CVP monitoring through the HD catheter. During surgery, a severe bleeding occurred with a Hb decline to 7,2g/dL. As no surgical cause for the bleeding was identified, we performed a ROTEM test and consulted with a hemotherapy specialist. A total of 4 units of RBCs was administered, followed by repeated blood gas analysis . ROTEM showed an increase in the coagulation time (CT) by the INTEM test with a normal CT by the HEPTEM test, suggesting the effect of heparin. It was confirmed with the dialysis service that no heparin was utilized for the HD therapy. All vials in the operating room were verified and no heparin was found. However, the dialysis catheter, locked with heparin (estimated amount of 11000U), was used during the procedure with no previous aspiration. Protamine was then administered allowing a progressive resolution of the hemorrhage. Transfer to PACU ensued uneventfully with Hb 10.2g/dL. The incident was registered in the hospital’s health events reporting system.

**Discussion**: It is important being aware of all medical treatments as they may result in possible harmful events. Knowing medical devices used for clinical practice is crucial to securely prevent improper management. HD central catheter was used intraoperatively to minimize redundant invasive puncture which is not risk-free. Thus, an alternative access site would be available for further employment. Perioperative period has a higher risk of health adverse events. Early recognition and prompt correction of any adverse events is essential to minimize impact and prevent worse outcomes. Reporting all adverse events is key to collect incident data and provide an evidence base for the development of safety solutions.

**Learning points**: Intraoperative adverse events are under-reported and may lead to increased postoperative mortality, morbidity, and length of stay.