Intrathecal tranexamic acid accident and their reporting system in India

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Abstract

The incidence of drug administration errors in hospitals in India is not known. We aimed to extract and investigate India-specific incidents of intrathecal tranexamic acid (TXA) administration during spinal anaesthesia. Our secondary aim was to identify any publications related to national drug error and reporting systems for hospitals in India. We analysed eleven published reports of tranexamic acid administration intrathecally in place of heavy bupivacaine. The primary cause was the availability of look-like TXA and local anaesthetic (heavy 0.5% bupivacaine) ampoules in operating rooms. We found three manufacturers designed, manufactured and supplied identical TXA and heavy bupivacaine ampules. In addition, different manufacturers had similar products available in operating rooms. We searched PubMed and Google Scholar for any publication on India's national medication error reporting system for hospitals. There was no publication on the national medication safety system involving hospitals. It demonstrates there needs to be a federal structure to report and monitor medication administration and other types of errors in hospitals in India. We highlight potential difficulties and barriers in creating a national system to notify, monitor and prevent medication errors in hospitals in India.

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