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dialysis, normal saline flushes can be added to dialyzer to improve metabolic alkalosis.

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COINFECTION WITH COVID-19 AND CYTOMEGALOVIRUS IN KIDNEY TRANSPLANT RECIPIENTS – A CASE SERIES:

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The coinfection with novel coronavirus disease (COVID-19) and cytomegalovirus (CMV) among disease donor kidney transplant (DDKT) recipients is rarely reported, to date. We present a case series of 3 DDKT recipients coinfected with COVID-19 and CMV.

A 37 year-old male with DDKT secondary to membranous glomerulonephritis, presented with pneumonia, acute kidney injury (AKI), positive COVID-19 and CMV. Patient was admitted to ICU due to worsening respiratory status and Ganciclovir-resistant CMV pneumonitis, for which high dose Ganciclovir was given. After 10 days in ICU, respiratory status, oxygen requirement, and CMV titers improved, and patient was subsequently discharged.

A 49 year-old female with DDKT secondary to diabetes, presented with pneumonia, AKI, positive COVID-19 and CMV. Despite initial standard treatment, patient remained hypoxic and subsequently intubated. After a prolonged and complicated 35 days ICU course, patient was eventually extubated and is currently stable.

A 49 year-old male with DDKT secondary to diabetes, presented with fever, abdominal pain, AKI, positive COVID-19 and CMV, without any respiratory compromise. Patient was started on Ganciclovir and continued on immunosuppression. Over the course of next few days, patient’s symptoms improved and was discharged.

Among DDKT recipients, the coinfection of COVID-19 and CMV is rare and very challenging in the setting of their immunosuppressed status. Interestingly, our stated 3 cases of coinfection and AKI were relatively young and presented within a year of transplant, and were successfully recovered.

The COVID-19 and CMV coinfection can lead to variable disease severity among DDKT recipients and can be treated with combined antiviral and immunosuppressive regime. A high index of suspicion for coinfection is warranted in immunocompromised patients with atypical or prolonged respiratory failure.

INCOMPATIBLE PLATELET TRANSFUSIONS – A CASE REPORT:

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Thrombotic microangiopathy (TMA) and acute kidney injury (AKI) are among the most serious peripartum clinical challenges for which various etiologies need to be clinically ruled out. We present a case report of a young female with full-term spontaneous vaginal delivery who developed TMA and AKI after massive postpartum hemorrhage. A 24 year-old female with history of pre-eclampsia was admitted for full-term spontaneous vaginal delivery. Postpartum course was complicated by massive hemorrhage due to uterine atony requiring lifesaving hysterectomy. As a result, massive transfusion protocol was triggered. On post-operative day 1, patient developed microangiopathic hemolytic anemia (MAHA), thrombocytopenia, and oliguric AKI. Hemodialysis and plasmapheresis were initiated. However, plasmapheresis was stopped once ADAMTS-13 was found to be negative. Kidney biopsy revealed TMA. While Eculizumab therapy was being planned, patient's hematological and renal parameters started to recover. Due to our patient's unusual clinical presentation, further investigations were performed which revealed accidental ABO incompatible platelets transfusion peripheratively. Renal and hematologic profile continued to improve and patient was discharged three weeks after delivery.

The peripartum TMA and AKI can be multifactorial, and in addition to common hematological disorders such as TTP, aHUS, and pre-eclampsia, ABO incompatible blood product transfusions can also lead to similar clinical presentation. We herein present a case report of peripartum TMA with unusual underlying etiology.

The ABO incompatible transfusion reaction is a less recognized cause of TMA in peripartum settings. Once traditional hematological disorders are ruled out, a dreaded triad of MAHA, thrombocytopenia, and AKI should prompt clinicians about rare possibility of transfusion-related reactions.

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THE CHANGING PATTERN OF ANTICOAGULANT USE IN DIALYSIS PATIENTS:

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Several studies have documented the frequent use systemic anticoagulation in dialysis patients. Problems like atrial fibrillation, venous thromboembolism, prosthetic heart valves and vascular graft patency are ever present in dialysis patients and commonly require use of systemic anticoagulation. Warfarin has been the traditional drug of choice. In this report we describe the frequency of new prescriptions for Apixaban in our dialysis centers since FDA approval in 2015.

Medical records of all patients enrolled in the Emory Dialysis Centers Program were reviewed for use of Coumadin or DOAC. New prescriptions per year were quantified. Indication for anticoagulation was obtained from the medical record.

Since 2011, 376 patients received new prescriptions for systemic anticoagulation out of 2265 enrolled in our dialysis centers (16.7%). Up to 2015 the only prescribed medication for anticoagulation was Warfarin. Starting on 2016, patients were prescribed Apixaban in increasing numbers and eventually became the most commonly prescribed systemic anticoagulant. Figure 4 presents the number of new prescriptions per year for Apixaban and Warfarin. Figure 2 displays the yearly percentage of new anticoagulant prescriptions represented by Apixaban. At the latest census, 58% of hemodialysis and 70% of peritoneal dialysis patients anticoagulated were on Apixaban. The most common indication was atrial fibrillation (33%), followed by venous thromboembolism (22%), calcific uremic arteriolopathy (4%), and others (mechanical valves, patency of