

DATE: 3/23/00

Refs Code: SP04

3/27/00 EVENT DIST SP04

cc: INEEL

Plankins, OSP
C. Martin, ASPD

AGREEMENT STATE

EVENT REPORT

**NEW MEXICO RADIATION LICENSING AND REGISTRATION
505-827-1871**

NM-00-01

LICENSEE:

St Joseph Medical Center
Albuquerque, NM

TYPE OF LICENSE:

Medical Institution
MI210

ISOTOPE:

Iridium - 192
3.856 Ci

EVENT AND DATE: (include cause and licensee corrective action)

After the third treatment with brachytherapy for endometrial cancer the patient developed erythema on two areas approximately 6 cm from the vaginal introitus. The physics department investigated and found no equipment malfunctions and assumed the attending physician had not properly placed the catheter in the vaginal applicator. The patient has recovered with no permanent damage to the affected areas. The estimated dose to the thigh area was approximately 500 R.

The Department has developed a new protocol calling for the physicians to re-check the catheter pro and post treatment with a witness present and signing off on the placement. Also, a new catheter/applicator system is on order. A new QA vag. cuff procedure is being documented.

10/13/99 event, 12/20/99 reported. Delay due to physician absence.

*Refs Code - SP04
OSP-007 Template*

DATE: 3/23/00

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cc: INEEL
P Larkin, ASP
C Mangin, ASPO**AGREEMENT STATE
EVENT REPORT****NEW MEXICO RADIATION LICENSING AND REGISTRATION
505-827-1871****NM-00-02****LICENSEE:**New Mexico Heart Hospital
Albuquerque, NM**TYPE OF LICENSE:**Medical Private Practice
MD143**ISOTOPE:**Tc99m
8 mCi**EVENT AND DATE: (include cause and licensee corrective action)**

A 8 mCi dose of Tc99-sestamibi was injected into the wrong patient. The patient had responded when called by last name only for his injection, there were two patients with the same last name scheduled.

The RSO has met with the NMT staff and they are now checking both the last name and first, as well as the test the patient is in for.
Event 1/18/00, reported 1/20/00.

DATE: 3/23/00

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cc: INEEL

P Larkin, DSP

C Mangin, ASPD

**AGREEMENT STATE
EVENT REPORT****NEW MEXICO RADIATION LICENSING AND REGISTRATION
505-827-1871****NM-00-03****LICENSEE:**Syncor Pharmacy Services
Albuquerque, NM**TYPE OF LICENSE:**Radiopharmacy
RP261**ISOTOPE:**Tc99m
8 mCi**EVENT AND DATE: (include cause and licensee corrective action)**

A 8 mCi dose of Tc99-Sulfur Colloid was to be dispensed when the intern drew up a dose of 8 mCi of Tc99-Choletec. The dose was sent out to an imaging facility, checked in by the NMT and administered. Shortly after he noticed the small bowel was imaging and decided the wrong drug was dispensed.

All Syncor pharmacists and interns were inserviced. The interns will show staff pharmacists what kit they are dispensing from and the dose. Only one kit at a time will be available for labeling and dispensing. After the dose is dispensed from the vial, the remaining volume is measured and the inventory updated.

Organ dose estimates were 3.92 rads to the large intestine upper wall, 3.01 rads to the lower wall and 2.47 rads to the small intestine. The gall bladder wall received 1.13 rads.

Event 3/8/00, reported 3/8/00.