

PRELIMINARY NOTIFICATION**November 20, 2000****PNO-RIII-000-40A****LICENSEE:** Aultman Hospital**EVENT NUMBER:** 37504**FACILITY:** Aultman Hospital**EVENT DATE:** 8 through 10/2000**UNIT:****REGION:** 3**Rx INFO:****LOCATION CODE:****DOCKETS:** State of Ohio Licensee**CITY:** Canton**STATE:** OH**EMERGENCY CLASS:** not applicable**SUBJECT:** BRACHYTHERAPY MISADMINISTRATIONS (UPDATE)**CONTACT:** James Lynch 630/829-9661 Geoffrey Wright 630/829-9602**DESCRIPTION:**

On November 8, 2000, the Ohio Bureau of Radiation Protection notified Region III (Chicago) that it had received a report of brachytherapy misadministrations to two patients at Aultman Hospital in Canton, Ohio. The misadministrations were found during a routine Quality Management Program audit by the hospital. The misadministrations involved iridium-192 temporary implants for treatment of cervical cancer. The misadministrations occurred when the incorrect units were used in entering the source strength into a new treatment planning computer. The source strength was entered as milligrams radium equivalent, instead of as millicuries.

Further review of therapy records by the licensee discovered two additional misadministrations in the same time period. Therefore, a total of five misadministrations to four patients were identified.

Patient One received two treatments using the incorrect data. The first treatment in September was 3330 centiGray (rads), instead of the prescribed 2000 centiGray (rads) dose. The second treatment in October was 3500 centiGray (rads), instead of the prescribed 2250 centiGray (rads) dose.

Patient Two received a radiation dose of 3520 centiGray (rads), instead of the prescribed dose of 1980 centiGray during a treatment in August.

Patient Three received a radiation dose of 3240 centiGray (rads), instead of the prescribed dose of 1890 centiGray during a treatment in October.

Patient Four received a radiation dose of 3150 centiGray (rads), instead of the prescribed dose of 2025 centiGray during a treatment in October.

The hospital reported that it did not expect any adverse effects due to the brachytherapy misadministrations. Patients and referring physicians were notified of the misadministrations.

The hospital will submit a written report to the Bureau of Radiation Protection. The Bureau plans to initiate an inspection on November 21, 2000.

Region III has notified the NRC Office of Nuclear Material Safety and Safeguards and the Office of State and Tribal Programs. The information in this Preliminary Notification has been reviewed with the Bureau of Radiation Protection.

This information is current as of 9:00 a.m. CST on November 20, 2000.