June 18, 2001

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-III-01-018

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region III staff on this date.

Facility	**Licensee Emergency Classification**
	___Notification of Unusual Event
Evanston-Northwestern Hospital	___ Alert
Evanston, Illinois	___ Site Area Emergency
License: IL-01248-02 (Agreement State)	___ General Emergency
	_X_ Not Applicable

SUBJECT: INTRAVASCULAR BRACHYTHERAPY MISADMINISTRATION

DESCRIPTION:

On June 18, 2001, the Illinois Department of Nuclear Safety (IDNS) notified Region III (Chicago) that the licensee reported a misadministration that had occurred on June 14, 2001. The misadministration involved a patient who was undergoing a Novoste intravascular brachytherapy system treatment.

During the course of coronary artery therapy, a patient was treated with 32.4 millicuries (1.2 GBq) of strontium-90 to prevent restenosis. When medical personnel were unprepared with a second syringe after the first syringe ran out of water, the prescribed treatment time was exceeded by 23 percent. The prescribed treatment time was 3 minutes and 26 seconds. The actual treatment time was approximately 4 minutes and 13 seconds.

IDNS is conducting an investigation into the incident. Illinois regulations require that the patient and referring physician be notified of the misadministration.

The NRC Office of Nuclear Material Safety and Safeguards, and the NRC Office of State and Tribal Programs have been notified. The information in this preliminary notification has been reviewed with IDNS management and is current as of 2 p.m. CDT.

CONTACTS:

James Lynch
(630) 829-9661

Monte Phillips
(630) 829-9806