April 26, 2002

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-III-02-018

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
Riverside Methodist Hospital	___ General Emergency
Columbus, OH	___ Site Area Emergency
Docket: BR44-12-97	___ Alert
License: 0212025-0070	___ Unusual Event
	_X_ Not Applicable

Subject: Intravascular Brachytherapy Misadministration (Overdose)

DESCRIPTION:

On April 26, 2002, the State of Ohio notified the NRC Region III (Lisle) office of a medical misadministration that occurred at Riverside Methodist Hospital while treating a patient with restenosis. The misadministration involved a Cordis Checkmate intravascular brachytherapy device containing a 14-seed iridium-192 (Ir-192) catheter.

During treatment of the patient on April 23, 2002, 10.9 Gy (1090 rad) of Ir-192 was administered to the patient, instead of the prescribed 8 Gy (800 rad). On April 26, 2002, the licensee reported the event as a misadministration to the State of Ohio because the administered dose exceeded the prescribed dose by 36 percent. No adverse affects are anticipated.

It appears the misadministration was a direct result of the licensee utilizing an inaccurate decay chart to calculate dose. The licensee notified the patient's physician and the patient of the misadministration. The State of Ohio will conduct an inspection on April 29, 2002, to review the circumstances surrounding the event.

The NRC Office of Nuclear Material Safety and Safeguards and the NRC Office of State and Tribal Programs were notified of the event.

The State of Ohio notified the NRC Operations Center of this misadministration at 1:00 p.m. EST on April 26, 2002. This information was discussed with the State of Ohio and is current as of 2:00 p.m. CST on April 26, 2002.

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