July 9, 2002

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-02-035

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 IV staff on this date.

Facility
Swedish Medical Center
Denver, Colorado
License No.: 251-01
Colorado Agreement State Licensee

Licensee Emergency Classification
___ Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
_X_ Not Applicable

SUBJECT: MEDICAL MISADMINISTRATION

DESCRIPTION:

On July 3, 2002, the Colorado Department of Public Health and Environment (CDPHE) notified the NRC Operations Center that a medical misadministration involving the use of an Iridium 192 (Ir-192) high dose rate (HDR) unit occurred on June 24, 2002, at a Swedish Medical Center located in Denver, Colorado.

The licensee notified the CDPHE on June 26, 2002, of a medical misadministration involving a patient that was underdosed from the prescribed dose for five fractions of the treatment plan. The brachytherapy applications involved using an HDR brachytherapy unit with a tandem/ovoid applicator. The licensee stated that during the treatment planning process, an incorrect magnification factor was used for the orthogonal films, which resulted in an underdose of approximately 50% (or more depending on the part of the treatment volume used for comparison). The prescribing physician plans to prescribe an additional brachytherapy application to compensate for the underdose. The prescribing physician contacted the patient on July 2, 2002.

NRC received notification of this occurrence by facsimile from the State of Colorado at 12:09 p.m. (EDT) on July 3, 2002.

Region IV has informed NMSS, OEDO, STP, and the region's PAO and SLO.

This information has been discussed with the State and is current as of 11:00 a.m. (CDT) on July 9, 2002.

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