

December 6, 2002

This event is not available for public disclosure per Agreement State request until 12/11/02

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-III-02-042

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

Northwest Community Hospital
Arlington Heights, Illinois
License: IL-01094-01
(Agreement State Licensee)

Licensee Emergency Classification

Notification of Unusual Event
 Alert
 Site Area Emergency
 General Emergency
 Not Applicable

SUBJECT: Intravascular Brachytherapy Misadministration

DESCRIPTION:

On December 6, 2002, the Illinois Department of Nuclear Safety (IDNS) reported to NRC a medical misadministration which occurred at Northwest Community Hospital, Arlington Heights, Illinois. On December 5, 2002, the licensee performed an intravascular brachytherapy procedure using a Guidant Corporation Galileo device with 85 millicuries of phosphorus-32. Using a three-step automated system, as the first step was completed, the authorized user intervened and repositioned the system markers to intentionally deliver an additional dose to a portion of the lesion being treated.

The calculated delivered dose was 24.6 gray, 23 percent greater than the original treatment prescription of 20 gray. The licensee reported that the clinical range for this treatment is 15-26 gray, so no adverse health effects are anticipated. The licensee will submit a 15-day written report to IDNS.

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

The Illinois Department of Nuclear Safety reported this event to the NRC Operations Center on December 6, 2002. This information was discussed with IDNS and is current as of 3:00 p.m. CST on December 6, 2002.

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