

February 21, 2003

***THIS EVENT IS NOT FOR PUBLIC DISCLOSURE PER AGREEMENT STATE REQUEST UNTIL 2/25/03.***

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-03-013

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**

Alta Bates Medical Center  
Berkeley, CA  
License No.: 0517-01  
California Agreement State Licensee

**Licensee Emergency Classification**

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

SUBJECT: BRACHYTHERAPY MEDICAL EVENT

DESCRIPTION:

On February 20, 2003, the California Radiation Health Branch (the Branch) notified NRC's Operations Center that a medical event involving a brachytherapy procedure that resulted in an estimated 50 percent overdose.

Alta Bates Medical Center, a California licensee, reported on February 19, 2003, that a patient, being treated for prostate cancer, received a .019 gigabequerel (0.52 millicurie) of iodine-125 seeds instead of the prescribed .013 gigabequerel (0.35 millicurie). The licensee reported that the event was caused by an error in the decay correction for the isotope. The referring physician has been notified and will discuss this incident with the patient. The Bureau is continuing to investigate the event.

Region IV received notification of this occurrence from NRC's Operations Center at 7:45 p.m. (EST) on February 20, 2003. Region IV has informed OEDO, NMSS, OSTP and the Region's PAO and SLO.

This information has been discussed with the State and is current as of 11:30 a.m. (CST) on February 21, 2003.

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