

August 26, 2003

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-III-03-036

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.

<u>Facility</u>	<u>Licensee Emergency Classification</u>
Community Hospital of Anderson	<input type="checkbox"/> Notification of Unusual Event
Anderson, Indiana	<input type="checkbox"/> Alert
License No.: 13-10205-01	<input type="checkbox"/> Site Area Emergency
Docket No.: 030-01643	<input type="checkbox"/> General Emergency
	<input checked="" type="checkbox"/> Not Applicable

SUBJECT: EVENT INVOLVING AN UNINTENDED DOSE TO AN EMBRYO/FETUS

DESCRIPTION:

On August 25, 2003, the licensee's Assistant Radiation Safety Officer notified the NRC Operations Center of an event involving an unintended dose to an embryo/fetus which occurred on August 8, 2003, at Community Hospital of Anderson, Indiana.

On August 8, 2003, the patient was scheduled to receive a [REDACTED] iodine-131 treatment for hyperthyroidism. Prior to the administration of the I-131 dosage, nuclear medicine personnel and the authorized physician user asked the patient if she was pregnant at that time. Hospital staff also offered the patient a pregnancy test. The patient informed the staff that she was not pregnant and declined to take a pregnancy test. The licensee proceeded with the administration of the dosage. However, the patient was unaware that at the time of the administration, she was approximately 15 weeks pregnant.

On August 25, 2003, the patient's physician informed the licensee of the event upon contacting the licensee to inquire about the fetal whole body and fetal thyroid doses. NRC staff and the licensee's consulting physicist are in the process of assessing these doses. The licensee was uncertain about the effects of the dosage to the embryo/fetus and will continue to evaluate the dose consequences.

The patient and the referring physician were notified of the event.

NRC Region III (Chicago) will perform a special inspection during the week of August 25, 2003, to review the circumstances surrounding the event. The State of Indiana and the NRC Office of Nuclear Materials Safety and Safeguards have been notified. The information in this preliminary notification has been reviewed with licensee management. The licensee notified the NRC Operations Center of this event at 4:20 p.m. (EDT) on August 25, 2003. This information is current as of 9:30 a.m. (EDT) on August 26, 2003.

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