Community
Health Network

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April 13, 2006

U.S. Nuclear Regulatory Commission
Region III
2443 Warrenville Road
Suite 210
Lisle, IL 60532-4352

Materials License 13-06009-01

Dear Sir or Madam:

This letter serves as the written report of an occurrence that may be a medical event. The event was identified during a routine inspection on 4/3-4/4/06. The HDR treatment in question occurred November 8, 2005.

Licensee Name: Community Hospitals of Indiana, Inc.
Prescribing Physician: Jianan Graybill, M.D.

Event Description: A bronchial HDR patient had a bronchial HDR lumencath applicator placed by the pulmonologist outside of the radiation oncology department. The patient came to the radiation oncology simulator for orthogonal radiographs for treatment planning. The radiographic marker (dummy) was inserted into the bronchial catheter without the metal interface connector to the HDR indexer. As a result, the source position markings were 0.7 to 1.0 cm deeper on the radiographs than would be truly occurring for treatment. This discrepancy was not realized until after the treatment. The radiation oncologist was informed that the active length prescribed was actually treated approximately 1 cm superior to the area indicated on the AP radiograph. The radiation oncologist felt that the margin on the distal side of the lesion was sufficient to treat the lesion despite the unintended approximately 1 cm pullback. The treatment was palliative and the oncologist had prescribed generous treatment margins.

Reason for Event: This occurrence represented a breakdown in proper procedure, by not properly preparing the bronchial lumencath prior to inserting the radiographic dummy marker. More experienced staff were not present for this procedure and those involved did not catch the variance. A contributing factor was placement of the lumencath outside the radiation oncology department. Written procedural steps allowed for one several individuals to place the dummy marker in the lumencath.

Effect on individual who received the treatment: The oncologist felt that the area of concern had been treated and the shift in the field did not represent a harmful variation in the treatment process. This was a palliative treatment only.

Actions taken to prevent recurrence: The written procedure was revised to assign the nurse as the individual who is responsible for preparing the lumencath and placing the radiographic marker. The therapist involved in imaging is to check that the catheter and marker is placed and labeled. The physicist is to provide supervision and an additional check on the setup.

Notification of Individual: The RSO and oncologist did not feel that this variance constituted a medical event on Nov. 8, 2005. The patient involved was terminal at the time of treatment and expired several weeks later. Consequently, no notification was made at the time of report.

This event was reported by phone to the NRC Operation Center on 4/5/06 at 13.31 EDT and was given Event number 42474.

Sincerely,

Andrea D. Browne, Ph.D.
Radiation Safety Officer

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A. Browne - Medical Imaging

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