



DEPARTMENT OF THE ARMY  
WALTER REED ARMY MEDICAL CENTER  
WASHINGTON, D.C. 20012

DOCKET NO. 30-01317  
SERIAL FILE 87-1

REPLY TO  
ATTENTION OF:

HSWP-QHP

JAN 6 1982

SUBJECT: Misadministration Report, Fourth Quarter 1981

US Nuclear Regulatory Commission  
Region I  
Office of Inspection and Enforcement  
631 Park Avenue  
King of Prussia, PA 19406

1. Pursuant to Title 10, Chapter 1, Code of Federal Regulations, Part 35, Section 35.43, the following information is provided to comply with the Nuclear Regulatory Commission's regulation on the reporting of diagnostic misadministrations of a radiopharmaceutical. Although the primary reason for the misadministration was that Patient "A's" first name was the same as Patient "B's" last name, the following description of the event omits patients' names to assure confidentiality of medical information.
2. On 26 October 1981 at 1000 hours, Patient "A", who was scheduled for a bone scan at 1000, checked into the receptionist's desk in Nuclear Medicine. He was told to have a seat and his approved consult was taken to the radiopharmacy for preparation of the dose. Twenty (20) mCi of TcMDP (bone agent) was drawn at 1010 hours, properly labeled, and carried to the dosing room with the consult as per usual procedure.
3. Mrs. Perla Wassel and SP5 Peter Veader were assigned to the dosing room for Nuclear Medicine on 26 October 1981.
4. Mrs. Wassel, upon receipt of the dose, went to the patient waiting room and called for Patient "A". At this time, Patient "B", who was waiting for a thyroid scan and to have some blood drawn for thyroid tests, got up and followed Mrs. Wassel into the dose room.
5. SP5 Veader had chosen to give the injection. He asked the patient if his name was Patient "A" and if he knew he was in the clinic for a bone scan. The patient said, "Patient "A's" first name, right?" Specialist Veader asked again, "Patient "A", right?" The patient responded affirmatively. Specialist Veader continued by explaining to the patient what a bone scan entailed and that he would have a delay time before scanning. Feeling confident that this was the correct patient and that he understood about the study, Specialist Veader injected the bone dose. The patient was given a return time that afternoon and he left the clinic.

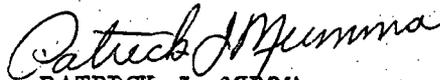
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6. At about 1100, Patient "A" approached the receptionist's desk and asked why he had not received his bone scan dose. The receptionist questioned the dosing room personnel on that point. This is when it was realized that a misadministration had occurred.
7. When Patient "B" returned to the clinic for his scan, LTC Norris, MC, a Nuclear Medicine fellow, informed him of the misadministration. This was thoroughly discussed with the patient. He was told that the estimated absorbed dose to the kidneys was 0.5 RAD, 1.0 RAD to the bladder, 0.6 RAD to the bone, and 0.1 RAD to the whole body.
8. The patient's referring physician, MAJ Zavadil, MC, was notified in writing of the misadministration by Drs. Norris and Van Nostrand.
9. The misadministration was a subject discussed at the next technologists' meeting and the staff meeting on 2 November 1981.
10. The responsibility for administering a radioactive dose to the proper patient rests with the technologist making the injection. In that regard, the technologist must be certain in his/her own mind that they are injecting the correct patient. It is recommended that during the identification process that the patient be further identified by asking the patient to recite the last four digits of his SSN, since the radiopharmacy dose tickets already bear this information. All inpatients who cannot respond will be verified by looking at their patient I.D. wrist bands.

FOR THE COMMANDER:

  
PATRICK J. MUMMA  
LTC, MSC  
Adjutant General

CF:  
TSG, HQDA (DASG-PSP-E), WASH DC 20310

MATERIALS RADIOLOGICAL PROTECTION SECTION  
LICENSEE EVENT REPORT

Docket No. 30-01317

MLER - RI-8 2-11

I. Action Control Data

Licensee Department of The Army

Event Description Dir. Misadmin of a Radioisotope

Event Date Oct 26, 1981

Report Date Jan 6, 1982

II. Reporting Requirement

- 10 CFR 20.402 - theft or loss
- 10 CFR 20.403 (a)(b) overexposure/ release
- 10 CFR 20.405 - 30 day report
- Other \_\_\_\_\_
- 10 CFR 35.42 Therapeutic Misadministration
- 10 CFR 35.43 Diagnostic Misadministration
- License Condition

III. Region I Response

- Immediate Site Inspection      Inspector \_\_\_\_\_ Date \_\_\_\_\_
- Special Inspection                      Inspector \_\_\_\_\_ Date \_\_\_\_\_
- Telephone Inquiry                        Inspector \_\_\_\_\_ Date \_\_\_\_\_

Licensee Representative and Title \_\_\_\_\_

- Information entered - Region I log and Outstanding Items List.
- Review at next routine inspection
- PN                       Daily Report

IV. Report Evaluation

- Description of Event
- Levels of R/M involved
- Cause of Event
- Corrective Actions
- Calculation adequate
- Letter to Licensee requesting additional information

Completed by J. McArthur

Date 2/9/82

Reviewed by \_\_\_\_\_

Date \_\_\_\_\_

Special Instructions or Comments: