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

REPLY TO
ATTENTION OF:

HSWP-QHP

SUBJECT: Misadministration Report, Second Quarter 1982

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 misadministration of a radiopharmaceutical.

2. On 19 April 1982 at approximately 1000 hours, Patient "A", was brought to the Nuclear Medicine Clinic for a liver scan. The patient was in serious condition on a respirator, and was accompanied by his physician, CPT Frank Opelka.

3. A renal transplant patient, Patient "B", was in "Picker" #4 and 5 camera room awaiting a renal scan. Her renal scan dose of 99mTc DTPA 15 mCi had been drawn at 0915 and was in the camera room.

4. A liver scan dose of 99mTc Sulfur Colloid 5 mCi was drawn at 0941 for Patient "A", and was taken to the same camera room for a flow study.

5. Both syringes were properly labeled as to radiopharmaceutical and presciption number. The patient dose tickets were attached around the lead syringe carriers of their respective doses. Each carrier was set with the patients' consult.

6. In light of the condition of Patient "A", on a respirator and accompanied by the attending physician, it was decided that his study should be done first.

7. Patient "B", was taken out of the camera room and Patient "A", was brought in to be done first.

8. Specialist Wayne Dunkle who was one of the Nuclear Medicine technologist working the two cameras in this camera room, stated that in the confusion and transfer of the two patients, he accidently knocked over both doses. Both syringes came out of their respective shields. He speculates that when he picked them up he put them back into the opposite syringe carriers.

W/15

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9. Specialist Dunkle then injected Patient "A", with the 99mTc DTPA renal dose for Patient "B", instead of the correct 99mTc Sulfur Colloid liver dose. As he finished the injection, he realized that the solution was not cloudy as 99mTc Sulfur Colloid should be, and that he had injected the wrong radiopharmaceutical. He immediately notified his supervisor Mrs. Joanna Beeler.

10. Dr. William Howard, CPT, MC the Nuclear Medicine physician on duty informed the patient's physician, Dr. Frank Opelka, who was with the patient, of the misadministration. Dr. Howard wrote a note in the patient's progress notes to document what had happended.

11. The misadministration was the result of failure on the part of the Nuclear Medicine technologist, SP5 Wayne Dunkle, to identify the proper dose for the proper patient. Even though the syringes could have been switched in their lead carriers, the "individual" syringe is labeled as to radiopharmaceutical and prescription number. The identity would be picked up at the time of final verification before injection as per clinic procedures.

12. The technologist responsible was counseled on the proper procedures to follow in administering doses and a special class was presented to the entire technologist staff on proper procedures and their responsibility in ensuring the dose intended for a patient is for that patient, the proper radiopharmaceutical, and the correct dosage range for the study to be done.

FOR THE COMMANDER:

Patrick J. Mumma

PATRICK J. MUMMA
LTC, MSC
Adjutant General

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

REGION I

Lic # 08-01738-02

MATERIALS RADIOLOGICAL PROTECTION SECTION
LICENSEE EVENT REPORT

Docket No. 30-1317

MLER - RI-82-094

I. Action Control Data

Licensee DEPARTMENT OF THE ARMY (WALTER REED ARMY MED. CT.

Event Description DIAGNOSTIC MISADMINISTRATION

Event Date 4-19-82 Report Date —

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 Misadminstration
- ☑ 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 ____

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

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 R. H. Ladun Date 7-27-82

Reviewed by [signature] Date 9-13-82

Special Instructions or Comments:

FORM 160 (Revised)
11/81