

File # 08-01738-02
CKET NO. 30-01317



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

MLER-R1-82-127

REPLY TO
ATTENTION OF:

4 OCT 1982

HS HL-HP

SUBJECT: Misadministration Report, Third 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 7 September 1982 at approximately 0820 hours, Dr. David B. Haseman, Resident, Diagnostic Radiology, who was on a Nuclear Pharmacy rotation, processed a nuclear medicine consultation/prescription for Patient "X". Patient "X" had been prescribed a 20 mCi dose of Tc99m Glucoptate (Tc GLUC) for a brain scan. The dose ticket had been prepared for Patient "X" indicating "brain scan" and Tc GLUC. Dr. Haseman prepared a syringe, labeled it with the purple label with Tc GLUC on it and added the prescription number label. He had previously been drawing several bone scan doses. He then drew a 20 mCi dose of bone agent (Tc MDP) for Patient "X" instead of Tc GLUC.
3. The syringe was labeled Tc GLUC and the dose ticket attached to the syringe stated that it was a brain scan dose of Tc GLUC for Patient "X". The dose was also within the $\pm 10\%$ dose limits at the clinic.
4. The dose was taken to the camera room where the study was performed. The dose was checked per clinic procedures prior to administration. The error could not be detected at this point.
5. Dr. Haseman realized what had happened when he returned from the scanning area. He immediately returned to pull the dose but the dose had already been injected.
6. Patient "X" and her physician, Dr. Smith of the Neurology Service, were notified of the error by Dr. Julio Garcia, Nuclear Medicine Physician on duty.

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7. As it turned out, the flow study was the most important part of the study for this patient. The flow study was accomplished satisfactorily with Tc MDP. Patient "X" did not have to receive any further radiation due to a repeat study and Patient "X" received the same radiation dose of 20 mCi had the Tc GLUC been administered.

8. The misadministration was due to human error in drawing the dose from the wrong vial. The clinic procedures could not identify the wrong agent in the syringe, when it was labeled incorrectly.

9. Dr. Haseman fully realized the seriousness of such an error.

FOR THE COMMANDER:

for Nancy G. Chy...
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-82-127

I. Action Control Data

DEPT. OF THE ARMY
Licensee WALTER REED ARMY MEDICAL CENTER
Event Description DIAGNOSTIC MISADMINISTRATION
Event Date 9-7-82 Report Date 10-4-82

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 _____

- 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. Luden

Date 10-25-82

Reviewed by [Signature]

Date 11-2-82

Special Instructions or Comments: