



DEPARTMENT OF THE ARMY
WALTER REED ARMY MEDICAL CENTER
WASHINGTON, D.C. 20307-5001

REPLY TO
ATTENTION OF:

Health Physics Office

4 OCT 1985

SUBJECT: Misadministration Report, Third Quarter 1985

US Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Sir:

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 for reporting the diagnostic misadministration of a radiopharmaceutical.

On September 5, 1985 Patient "X" was scheduled for the evaluation of a thyroid nodule at the Walter Reed Army Medical Center (WRAMC) Thyroid Clinic. The patient, presented to the Nuclear Medicine Clinic by mistake, was injected with 10 mCi of 99m TcO4 intravenously for thyroid scintigraphy without a signed prescription by a Nuclear Medicine physician. Analysis of the incident revealed that the identity of the patient was not checked properly and she was confused with another patient with a similar last name who had been scheduled for a thyroid scan. The patient was informed of the incident and taken to the Endocrinology Clinic where she was evaluated. No discernible side effects were observed. Dr. Jenifer Nouvo, Major, Medical Corps, the referring physician, was notified of the incident. Although the thyroid scan was essential for the workup of the palpable abnormality, the procedure was performed by accident and not ordered by the Nuclear Medicine physician.

The following steps were taken to prevent recurrence of this incident.

a. All patients must be identified by first name, last name and social security number. The latter is clinic policy.

8512120314 851004
REG1 LIC30
08-01738-02

W/17
RETURN ORIGINAL TO
REGION I

1X30/11

I. ACTION CONTROL DATA

Licensee WALTER REED ARMY MEDICAL CENTER

Event Description DIAGNOSTIC MISADMINISTRATION

Event Date 9-5-85

Report Date 10-4-85

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 _____

- FN 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/H involved
- Cause of Event
- Corrective Actions
- Calculation Adequate
- Letter to Licensee requesting additional information

Completed by: R.H. Redman

Date 11/25/85

Reviewed by: J. Kennerly

Date 12/9/85

V. SPECIAL INSTRUCTIONS OR COMMENTS