

Pic # 08-01738-02

REF NO. 30-01317

44-81-87-50



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

JAN 29 1987

REPLY TO
ATTENTION OF:

Health Physics Office

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

RETURN ORIGINAL TO
REGION I

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 to report the diagnostic misadministration of a radiopharmaceutical.

On January 1, 1987, Patient "X" was referred to Nuclear Medicine to undergo a ventilation/perfusion (V/Q) scan as the referring physician suspected the patient might have had a Pulmonary Embolus. The ventilation part of the scan was performed correctly. While preparing for the perfusion portion of the scan, the on-call technician made up TcDISHIDA used for hepatobiliary studies, instead of TcMAA and administered the patient 4mCi of TcDISHIDA. The technician involved stated that he was distracted while making up the agent and accidentally made up the incorrect agent. The patient was informed of the incident and advised that no discernible secondary effects were observed or expected. Dr. Sandy Kweder, the referring physician, was notified of the incident.

The following actions were taken to prevent recurrence:

- a. The technician was counseled by his supervisor with emphasis on the need for the proper identification of pharmaceutical agents during all stages of every procedure.
- b. A review of the present labeling and identification procedures used in the Nuclear Medicine Pharmacy for pharmaceutical agents was made to ensure they are clear and not easily confused.

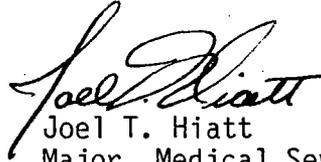
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c. A review of the proper procedures for identifying and making up agents was presented at the weekly Nuclear Medicine Technician meeting and particularly emphasized to all Nuclear Medicine Pharmacy personnel.

Sincerely,



Joel T. Hiatt
Major, Medical Service Corps
Adjutant General

Copy Furnished:

Department of the Army
Office of the Surgeon General
5111 Leesburg Pike
Falls Church, Virginia 22041-3258

REGION I
MSS LICENSEE EVENT REPORT

License No. 08-01738-02

Docket No. 30-01317

MLER-RI-88-50

I. ACTION CONTROL DATA

Licensee DEPARTMENT OF THE ARMY

Event Description DIAGNOSTIC MISADMINISTRATION

Event Date 1-1-87

Report Date 1-29-87

II. REPORTING REQUIREMENT

- | | |
|---|---|
| <input type="checkbox"/> 10 CFR 20.402 - theft or loss | <input type="checkbox"/> 10 CFR 35.42 Therapeutic Misadministration |
| <input type="checkbox"/> 10 CFR 20.403(a)(b) overexposure/release | <input checked="" type="checkbox"/> 10 CFR 35.43 Diagnostic Misadministration |
| <input type="checkbox"/> 10 CFR 20.405 - 30 day report | <input type="checkbox"/> -License Condition |
| <input type="checkbox"/> Other _____ | |

III. REGION I RESPONSE

- | | | |
|--|-----------------|------------|
| <input type="checkbox"/> Immediate Site Inspection | Inspector _____ | Date _____ |
| <input type="checkbox"/> Special Inspection | Inspector _____ | Date _____ |
| <input type="checkbox"/> 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

- | | |
|--|---|
| <input checked="" type="checkbox"/> Description of Event | <input checked="" type="checkbox"/> Corrective Actions |
| <input type="checkbox"/> Levels of R/M involved | <input type="checkbox"/> Calculation Adequate |
| <input checked="" type="checkbox"/> Cause of Event | <input type="checkbox"/> Letter to Licensee requesting additional information |

Completed by: R.A. Jordan Date 3-12-87

Reviewed by: J.D. Kinnema Date 3/17/87

V. SPECIAL INSTRUCTIONS OR COMMENTS