REGION I
NMSS LICENSEE EVENT REPORT

License No. 08-01738-02

Docket No. 030-01317

MLER-RI-88-043

I. ACTION CONTROL DATA

Licensee WALTER REED ARMY MEDICAL CENTER

Event Description diagnostic misadministration

Event Date 2-10-88 Report Date 2-19-88

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 35.33 Therapeutic Misadministration

[X] 10 CFR 35.33 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

[X] Information entered - Region I log and Outstanding Items List

[X] Review at next routine inspection

IV. REPORT EVALUATION

[X] Description of Event

[X] Levels of R/M involved

[X] Cause of Event

[X] Corrective Actions

[ ] Calculation Adequate

[ ] Letter to Licensee requesting additional information

Completed by: E. Ullrich Date 2/29/88

Reviewed by: J. D. Kinsman Date 3/29/88

V. SPECIAL INSTRUCTIONS OR COMMENTS

Thyroid dose: 2.6 rem, upper GI dose 2.4 rem

2/57

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

License No. 08-01738-02
Docket No. 030-01317
MLER-88-043

19 FEB 1988

REPLY TO ATTENTION OF:

Health Physics Office

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

Dear Sir:

Persuant to Title 10, Chapter 1, Code of Federal Regulations, Part 35, Section 35.33, the following information is provided to comply with the Nuclear Regulatory Commission's regulation to report the diagnostic misadministration of a radiopharmaceutical.

On February 10, 1988, Patient "X" was refered to Nuclear Medicine to undergo a bone scan for the identification of possible metastatic sites. The patient was inadvertently given 20mCi of technetium sodium pertechnetate ($99mTcO_4$) instead of 20mCi of technetium medronate (99mTcMDP). The error was discovered upon review of the scan, in which the distribution of radiopharmacutical was that of $99mTcO_4$ (blood pool uptake and salivary glands, thyroid and stomach) and not of the distribution expected of the bone tracer. The administration of the incorrect pharmaceutical was made because of a lapse in following the radiopharmacy standard operating procedure by the radiopharmacy technologist. The dose prepared prior to Patient "X's" was $99mTcO_4$ for a thyroid scan. The technologist did not follow procedure in returning the $99mTcO_4$ vial to the partition separating the product for immediate use from those awaiting use. When Patient "X's" prescription arrived the dose was drawn from the $99mTcO_4$ vial. The patient was counseled immediately and advised that no significant sequela was expected. Dr. Skoog, 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. All personnel working in the radiopharmacy have been reminded of the necessity of maintaining a proper dispensing procedure which emphasizes separation of radiopharmaceuticals in the dose preparation area, i.e. only one product will be in the preparation area at a time.

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1X

Return Original to Region I

c. The 99Mo/99mTc generator will be eluted with a 10cc vial instead of a 20cc vial when preparing the $99mTcO_4$. This will make it more distinct from the 99mTcMDP.

Sincerely,

Michael C. Hicks

Michael C. Hicks
Major, Medical Service Corp
Executive Officer
301-427-5704

Copy Furnished:

Commander
US Army Health Services Command
Fort Sam Houston, Texas 78234-6000

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5111 Leesburg Pike
Falls Church, Virginia 22041-3258