October 20, 1995

## PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-I-95-045

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This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by Region I staff (King of Prussia, Pennsylvania)n on this date.

## **Facility**

## Licensee Emergency Classification

Walter Reed Army Medical CenterNotification of Unusual EventDepartment Of The ArmyAlertWashington,District Of Columbia 20307-5001Site Area EmergencyDockets: 03001317 License No: 08-01738-02General EmergencyX Not ApplicableX

Subject: UNPLANNED ROUTE OF ADMINISTRATION OF IODINE-131 TO ONE PATIENT

On October 20, 1995, the licensee reported a potential therapeutic misadministration. The potential misadministration involved a thyroid patient who was prescribed a dose of 29.9 millicurie of iodine-131 (I-131).

The iodine dose was to be administered through a tube which would deliver the I-131 to the patient, intravenously. The patient had surgery and numerous tubes were connected to the patient. The I-131 was injected into the wrong tube. The licensee stated that the I-131 was injected into a suction tube from an abdominal incision. The licensee immediately removed the padding material from the incision and found that most of the I-131 was locally absorbed into the padding. The licensee's initial estimates of the I-131 absorbed into the patient's body was approximately 6 millicurie.

The licensee is planning to complete the original administration today, to achieve the intended prescribed dose of 29.9 millicurie.

The District of Columbia has been notified of the potential misadministration. The Region I Office of Public Affairs is prepared to respond to media interest. The Region I Office will continue to follow-up on the licensee's actions to prevent recurrence. The information in this notice is correct as of 2:00, October 20, 1995.

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