



PARKVIEW

COMPREHENSIVE CANCER CENTER

Attn: Bob Gattone

fax # 630-515-1259

02/10/2009

Jim Caldwell
Regional Administrator
U.S. NRC, Region III
2443 Warrenville Rd., Suite 210
Lisle, IL 60532-4352

From Subhash Sharma
3/11/09
Per your phone call.

Sheet No. 03001593

Incident Report

Re: Lost I-125 Seed

Licensee: Parkview Health
Location: Parkview Comprehensive Center, Fort Wayne, IN
License #: 13-01284-02
Radioactive Material: Iodine 125 (Bard Brachysource I-125 (STM1251))
Quantity Lost: One seed
Activity: 0.337 mCi on 1/28/09
Date of incident: 02/02/2009

Telephone report made with NRC Operations Center: 02/10/09

Description

A shipment of 69 I-125 prostate seeds (68 seeds pre-loaded in 22 needles and one loose calibrated seed stored in a vial) arrived from the manufacturer for a prostate implant procedure scheduled at 8:00AM on Wednesday, 01/28/09. Upon receipt, on Thursday, 01/22/09, the seeds were taken to the sealed source room and stored in a locked cabinet. On Friday, 01/23/09, a medical physicist conducted the assay of the calibrated seed and verified the number of seeds included in the shipment per our order. Based on a report from the medical physicist who conducted the assay, the calibrated seed was visually confirmed to be in the vial at the conclusion of the assay.

On Wednesday, 01/28/09, 67 seeds from 21 needles were implanted successfully by the authorized user. After the procedure was completed, the dosimetrist participating in the seed implant opened the vial and downloaded the remaining unused seed from the needle. She visually confirmed only one seed in the vial, and documented that all sources were present in the implant worksheet (see attached). A patient survey was conducted, and the results were documented accordingly. An area survey of the linens, floor, trash, and surrounding areas was also conducted. All readings were less than 0.01mR/hr.

Follow-up Action

The loss was not identified until 10:30AM on Monday, 02/02/09 when another medical physicist completed the post implant chart audit. During the audit, it was found that the source count documentation was in error. Upon learning of the discrepancy in the post-implant source count, the dosimetrist was contacted to account for the missing source. Based on follow-up with the dosimetrist,

she verified that the vial was empty prior to downloading the remaining unused seed. A thorough radiation survey was conducted of the surgical suite, sealed source room, physics department offices, and interconnecting hallways. The Ludlum Model 3 GM counter with scintillation probe was used for all surveys. At 1:30PM on Monday, 02/02/09, the Radiation Safety Officer was notified. The RSO arrived onsite at 2:00PM, and the search for the missing seed continued, to no avail. In addition, the physicist who performed the assay surveyed his personal automobile and residence to verify that the missing seed had not been accidentally transported with his belongings.

Current Status

At this time, the seed has not been located. It is still unclear as to precisely when the seed was lost based on the information provided by the medical physicist and the dosimetrist.

Radiation Exposure

To our knowledge, there was no radiation exposure to the individuals involved.

Corrective Action

To prevent this from recurring, a room survey will be conducted upon completion of the seed assay. Also, prior to transporting radioactive material to the operating room, persons performing the prostate seed implant will inventory sources to assure that all sources are present. Post implant chart audits will be performed on the day of the prostate seed implant so as to detect discrepancies in the source count on the same day. A physics staff in-service was held on 02/10/09 to review the policy and procedure and to emphasize the new timely survey and audit requirements for prostate seed implants.

Subhash Sharma

Subhash C. Sharma, Ph.D.
Radiation Safety Officer
Parkview Health
Comprehensive Cancer Center
11141 Parkview Plaza Dr., Suite 110
Fort Wayne, IN 46845

Enclosures: Copy of Prostate Implantation Worksheet
Copy of Prostate Implantation Quality Management Document

cc: Rae Gonterman, Executive Director, Oncology Services
Dan Garman, Senior Vice President



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03/25/2009

Fax # 630 - 515 - 1259

Bob Gattone
U.S. NRC, Region III
2443 Warrenville Rd., Suite 210
Lisle, IL 60532-4352

Re: Revised Incident Report of 2/10/2009

Dear Bob,

Pursuant to our telephone conversation this afternoon, I am revising the incident report of February 10, 2009, to include the following additional details regarding the circumstances leading to the lost I-125 seed.

I believe that the unused seed most likely fell out of its vial following the implant procedure, while in the operating room. I have observed that the I-125 seeds are prone to static buildup problems, and have the tendency to cling to plastic vial lids, glass walls, and other surfaces.

Most likely, the lost seed was discarded with the normal trash from the operating room. Based on the relatively low activity and low energy of the I-125 seed and measured background readings in the operating room, there was no radiation exposure to personnel or members of the public due to this lost seed.

If I can answer any questions, please call me at 260-266-9147.

Regards,

Subhash Sharma

Subhash C. Sharma, Ph.D.
Radiation Safety Officer
Parkview Health
Comprehensive Cancer Center
11141 Parkview Plaza Drive, Suite 110
Fort Wayne, IN 46845