Heart Clinics NORTHWEST

Fellows
American College of Cardiology

www.heartclinicsnw.com

Nuclear Cardiology
Accredited Nuclear Cardiology Laboratory

ICAEL
Accredited Echocardiography Laboratory

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2009
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USNRC Region IV

1 September 2009

Subject: Report of Medical Event

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Heart Clinics Nortwest
700 Ironwood Dr, suite 350
Coeur d'Alene, Id. 83814

NRC License # 46-27704-01

Prescribing Physician: Eteri S Byazrova MD

Description of Event:

On Aug 24th 2009 at around 1:00 pm, a patient scheduled to receive 25 mCi of Tc99m Pertechnetate was given an 8 mCi dose of Tc99m Sestamibi prescribed for an other patient.

This event occurred while the Technologist in question had two patients in process. A gated Blood pool patient he had pretreated for a red blood cell tag with 25 mCi Tc99m Pertechnetate. The second patient was having an iv started by a nurse for a Myocardial Perfusion Study, with a resting dose of 8 mCi Tc99m Sestamibi. The Tech assayed both doses and placed the Sestamibi Dose in the shielded transport container and left the Pertechnetate in the dose calibrator. He then worked on other duties while waiting to perform his injections. When it came time to inject his Gated Blood pool patient he grabbed the transport container with the wrong agent and administered it. He noticed the error when he started imaging. He told the patient what had happened and also informed the referring physician and myself. The patient was rescheduled for the test the next day. The Second patient was unaffected by this chain of events.

The patient's exposure from this error was not high enough to require a report of a medical event under 35.3045. Neither the whole body,or critical organ doses, approached the threshold of 5 rem and 50 rem respectively. I have calculated these exposures using the manufacturer's product insert forTc99m Sestamibi using the higher dose figures from a 4hr vs. a 2hr void assumption. The whole body dose was calculated to be 0.133 rem. And the organ dose was 2.56 rem to the entire large intestine.

Cause of Event:

This event occurred because the technologist was attempting to multitask in the Hot Lab. He then failed to double-check his work upon his return to the Hot Lab after an absence.

There were no adverse effects to the patient.

Remedial Actions:

The Technologist involved, has been counseled as to the critical importance of preventing misadministrations, and the need to strictly adhere to operating procedures designed to prevent such occurrences. We will also hold an additional radiation safety training session for our technical staff to discuss this event. We will also review and reiterate the policies and procedures Heart Clinics Northwest has in place to prevent Medical Events from happening.

As stated earlier. The patient was told about the misadministration at the time of the event.

Wayne Whitney RSO