Addendum to the report submitted to the NRC regarding the medical event discovered on September 25, 2009

The following is an addendum to the report submitted to the NRC, pursuant to 10 CFR 35.3045, regarding the medical event that was discovered on September 25, 2009. This addendum addresses new information obtained through VASDHS's investigation and additional corrective actions taken to prevent recurrence.

a) New information obtained:

After interviewing the Nuclear Medicine technologist involved in the administration of the I-131 therapy dose and analyzing the G-tube removed from the patient with a gamma camera, it was found that the likely cause of the medical event was the inadvertent administration of radioactivity into the G-tube's balloon port.

A renowned Dosimetry consultant was hired by the facility and provided dosimetry data to perform a thorough dosimetry assessment for the medical event. In his final report, the consultant states that the patient received significant levels of radiation dose to the stomach wall and surrounding organs.

The efficacy of the therapy may have been reduced because the complete dose was not delivered to the patient as prescribed. The medical condition of the patient continues to be closely followed by both the Nuclear Medicine Service at the VA San Diego and the patient's endocrinologist at the VA Las Vegas. No sequelae specifically attributable to the unanticipated radiation exposure have been identified or reported.

b) Additional corrective actions taken:

In addition to the corrective actions documented in the original report, the permittee has temporarily limited the involvement of the technologist that administered the dose to the patient, to procedures that do not require a written directive until written procedures are reviewed and approved and he is properly trained. The details of the medical event have been discussed with the entire Nuclear Medicine staff. Draft procedures have been developed and reviewed by Nuclear Medicine Personnel.