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Protecting People and the Environment

Status of Medical Events FY 2010

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Medical Events 2010

- **47 Medical events reported - FY 2009**
- **49 Medical events reported - FY 2010**

	FY09	FY10
35.200	1	1
35.300	5	4
35.400	17	25
35.600	14	12
35.1000	10	7

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Medical Events 2010

Diagnostic Medical Event

35.200 1

Communication errors

- Referring physician intended I-123
- Wrote I-123 prescription and gave to patient
- Physician's office faxed request for I-131
- Hospital gave I-131
- Hospital refused patient's written prescription
- Technologist noted patient had thyroid

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Medical Events 2010

35.300 Medical events 4

– Oral Sodium Iodide I-131 3

- Wrong Patient
- Left capsules in vial (2 events - 5 capsules)

– MIBG I-131 1

Preparation volume error lead to air in infusion line

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Medical Events 2010

35.400 Medical events 25

- Gynecological 3
- Anus 1
- Prostate 21

35.400 Medical Events

Gynecological Cs-137 3

- Applicator came out after 20 minutes – may have received 76 rem to thigh
- Applicator dislodged after vigorous coughing after 20 hours (total prescribed 45 hours)
- Failure to place sources in applicator one fell out and fell on buttocks (1,050 rad) other was missing and found in trash

Anus I-125 1

- 4 cm superior to intended location – 10 cm mark mistaken for 5 cm mark

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35.400 Medical Events

Prostate (40 Patients) 21

- 4 licensees had multiple medical events - licensee not reviewing results against medical event criteria
  - DVA had 11 under one medical event report
  - Mercy St Vincent Medical Center and an associated facility had 9 reported individually
  - Marshfield Clinic had 9 in one report and 1 in another report
  - Jewish Hospital had 2 events in one report
  - Bristol Hospital had 2 events in one report

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35.400 Medical Events

Prostate (Continued)

- 20 under dose to the prostate, no reason given
- 3 Over dose to prostate, no reason given
- 2 Multiple seeds eliminated from bladder or urethra
- 1 Tumor volume increase due to edema
- 11 Suboptimal dose distribution, poor placement, poor visualization, incorrect identification of prostate
- 3 Over doses to other organs (e.g., urethra)

Medical Events 2010

35.600 Medical events 12

- HDR 9
  - Mammosite 2
- Gammaknife 3

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35.600 Medical Events

HDR Only (11 patients) 7

- 1 Software failure
- 2 Human error
  - hit “auto radiograph” instead of “treatment” button
  - – entered treatment site incorrectly
- 3 Catheter issues-tight bend, catheter movement
- 1 No reason given – 5 patients 30-50% under dosing

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35.600 Medical Events

HDR Mammosite (3 patients) 2

- 2 source positioning error not discovered until after 10 of 10 fractions for patient 1 and 8 of 10 fractions for patient 2 –

- 1 incorrect distance measurement – used damaged source positioning simulator tool

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35.600 Medical Events

Gammaknife 3

- removed right anterior pin from frame - left pin slipped 2 cm superiorly
- wrong coordinates put in 1st 5 of 10 fractions – used x coordinate value for both x and z
- head immobilization bracket not fully secured – patient pain

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Medical Events 2010

35.1000 Medical events 7

- Perfexion 2
- Microspheres 4
- Intravascular Brachytherapy 1

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35.1000 Medical Events

Perfexion 2

- Wrong site – intended left side gave to right side of brain error discovered at 1.4 minutes into 30 minutes
- Failed computer disk froze treatment screen gave fatal error and terminated treatment intended

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35.1000 Medical Events

35.1000 TheraSpheres 2

- Wrong site intended left lobe of liver delivered to right lobe – right lobe was scheduled to get dose on later date prescribed for later date 12,500 rad got 7,600 rad
- Waste container assay indicated 25% of pretreatment activity – iodine contrast media put in catheter, thought this impeded or caused aggregation.

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35.1000 Medical Events

SirSpheres 2

- Leakage around stopper – manufacturer confirmed leakage, but thought physcian put too much pressure to V-vial
- Thought procedure delivered entire dose with out complication, but about 4.4 mCi of intended15.4 mCi left in tubing vial and other contaminated items

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35.1000 Medical Events

Intravascular Brachytherapy

- Wrong treatment time selected for treatment intended 1,840 rad gave 2300 rad – AU did not sign written directive before administration