



**Dante C  
Huntsman/DHUN/CC01/INEE  
L/US**

10/16/2006 01:56 PM

To Mark.Light@odh.ohio.gov  
cc "Michael Snee" <Michael.Snee@odh.ohio.gov>, "Stephen  
James" <Stephen.James@odh.ohio.gov>  
bcc Thomas W Smith/SMITTW/CC01/INEEL/US@INEL  
Subject Fw: Medical event

Mark,

The NMED event is now listed as complete and closed (update may be seen tomorrow morning on the NMED website). Thanks for the additional information (corrective action).

Sincerely,  
Dante Huntsman  
NMED Project

----- Forwarded by Dante C Huntsman/DHUN/CC01/INEEL/US on 10/16/2006 01:53 PM -----

**Thomas W  
Smith/SMITTW/CC01/INEEL/  
US**

10/16/2006 07:02 AM

To Dante C Huntsman/DHUN/CC01/INEEL/US@INEL, Robert L  
Sant/ZAP/CC01/INEEL/US@INEL  
cc  
Subject Fw: Medical event

----- Forwarded by Thomas W Smith/SMITTW/CC01/INEEL/US on 10/16/2006 07:01 AM -----



**"Mark Light"  
<Mark.Light@odh.ohio.gov>**

10/13/2006 08:42 AM

To "Thomas W Smith" <Thomas.Smith@inl.gov>  
cc "Michael Snee" <Michael.Snee@odh.ohio.gov>, "Stephen  
James" <Stephen.James@odh.ohio.gov>  
Subject Medical event

Tom,

The medical event listed below was entered into the NMED system by the NRC. I cannot close this event. Would you please close this or tell me how I get this closed...Thanks Mark

The Corrective action will be to observe compliance to newly established procedures through periodic inspections.

**NMED Item Number: 060475**

**Narrative:****Last Updated:** 07/31/2006

The licensee reported that a patient prescribed to receive a prostate seed implant procedure received seeds with 27% higher activity than intended. The licensee stated that the seed implant plans are specified in air kerma units on their computer planning system. However, the ordering of seeds is specified in mCi. When the seeds for this patient were ordered, the activity was not changed to mCi. The patient was prescribed to receive 111 I-125 seeds, each with an activity of 14.58 MBq (0.394 mCi). The patient was implanted with seeds that had an activity of approximately 18.5 MBq (0.5 mCi), each. The physician, patient, and the State of Ohio were notified of the incident on 7/13/2006. The State Agency inspected the licensee's facility on 7/18/2006. The INL has requested additional information for this event.

**Event Date:**

07/10/2006

**Discovery Date:**

07/12/2006

**Report Date:**

07/13/2006

**Licensee/Reporting Party Information:**

Regulated By:	AGREEMENT STATE	Reciprocity:	NONE
License Number:	OH-02120780000	Name:	AKRON GENERAL MEDICAL CENTER
Docket Number:	NA	City:	AKRON
Program Code:	NA	State:	OH
Responsible NRC Region:	3		

**Site of Event:**

Site Name:	AKRON	State:	OH
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**Additional Involved Party:**

License Number:	NA	City:	NA
Name:	NA	State:	NA

**Other Information:**

NRC Reportable Event:	Y	Abnormal Occurrence:	N
Agreement State Reportable Event:	Y	Investigation:	Y
Atomic Energy Act Material:	Y	Record Complete:	R
Consultant Hired:	N	Event Closed by Region/State:	N

**Event Cause:**

MD2 - MEDICAL EVENT  
Cause: SOURCES SELECTED WITH INCORRECT ACTIVITY

**Corrective Actions Information:**



MD2

Reporting Requirement: 35.3045(a)(1)(i) - Total dose delivered that differs from the prescribed dose by 20% or more; and differs from the prescribed dose by more than 0.05 Sv (5 rem) EDE, 0.5 Sv (50 rem) to an organ or tissue, or 0.5 Sv (50 rem) SDE.

**Reference Documents:**

Reference Document Number:	Entry Date:	Retraction Date:	Type of Report:
EN42729	07/31/2006		EVENT NOTIFICATION REPORTED FROM AN AGREEMENT STATE

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