TOP

| General Information or Other | Event Number: 43192 |
|---|---|
| Rep Org: OHIO BUREAU OF RADIATION PROTECTION<br>Licensee: AKRON GENERAL MEDICAL CENTER<br>Region: 3<br>City: AKRON State: OH<br>County:<br>License #: 02120-78-0000<br>Agreement: Y<br>Docket:<br>NRC Notified By: MARK LIGHT<br>HQ OPS Officer: JEFF ROTTON | Notification Date: 02/27/2007<br>Notification Time: 14:04 [ET]<br>Event Date: 09/27/2006<br>Event Time: [EST]<br>Last Update Date: 03/01/2007 |
| Emergency Class: NON EMERGENCY<br>10 CFR Section:<br>AGREEMENT STATE | Person (Organization):<br>ROGER LANKSBURY (R3)<br>GREG MORELL (FSME) |

**Event Text**

AGREEMENT STATE REPORT - POTENTIAL MEDICAL EVENT

At 1405 EST on 02/26/07, the state received a report via the US Mail from Akron General Medical Center. On 09/27/06 a patient was receiving a 10 fraction dose for Mammo-site Breast Brachytherapy using a HDR afterloader with a total prescribed dose of 3400 RAD. A problem with the PLATO planning computer digitized the breast image using an incorrect treatment factor which doubled the fractional dose. The same total prescribed dose was delivered but in 5 vice 10 fractional doses. The patient was made aware of the error on 09/27/06. Tissue necrosis was observed due to the procedure, but it is being evaluated if any additional necrosis occurred due to the delivery of the total dose in 5 fractions vice the 10 planned fractional doses. The licensee is taking corrective action to prevent a reoccurrence of this type of error.

* * * UPDATE FROM FSME (FLANNERY) TO KNOKE ON 02/28/07 * * *

This event has been reviewed and determined to be a reportable medical event.

* * * UPDATE FROM OHIO DEPARTMENT OF HEALTH (MARK LIGHT) TO HUFFMAN ON 03/01/07 AT 1000 EST * * *

The State provided the following update to this report via facsimile:

"On September 28, 2006, the licensee notified the ODH Bureau of Radiation protection that they had an event which did not meet the reporting requirement of a medical event but they were revising their HDR program to prevent a recurrence. The Bureau requested a report that was received on February 26, 2006. The patient was to receive a total dose of 3400 rad total dose through 10 fractions of 340 rad each. The patient received 5 fractions of 680 rad for a total dose of 3400 rad. Upon review of the report it was determined by consultation with NRC Region 3 that a medical event did occur because 'Prescribed Dose' for remote afterloaders includes Total Dose and Fractionated dose. The reason for the event was the Physicist entered the wrong planning film magnification into the treatment system. The patient has experienced some tissue necrosis at the treatment site, although some necrosis is expected with this therapy (MammoSite). The necrosis may have been exacerbated by the dosage scheme. The patient is being followed by her attending physician. The patient and attending physician were notified on 09/27/2006. The Bureau conducted an inspection on November 2, 2006 and identified problems with the licensee's HDR program an additional inspection will be conducted during the week of March 5, 2007."

The R3DO (Lanksbury) and FSME EO (Morell) were notified.

Ohio Report OH2007-11

A "Medical Event" may indicate potential problems in a medical facility's use of radioactive materials. It does not necessarily result in harm to the patient.