Thomas W Smith/SMITTW/CC01/INEEL/US
06/25/2007 09:17 AM

To "Michele Burgess" <MLB5@nrc.gov>
cc Dante C Huntsman/DHUN/CC01/INEEL/US@INEL, Robert L Sant/ZAP/CC01/INEEL/US@INEL
bcc
Subject Re: Fwd: Event 070024 -Label as Potential AO

Michele:

We have marked 070024 has a P AO. Note, that we checked our backup files and documentation - we don't think that this event was not previously marked as a P AO.
"Michele Burgess" <MLB5@nrc.gov>

"Michele Burgess" <MLB5@nrc.gov>
06/25/2007 04:38 AM

To "Thomas W Smith" <Thomas.Smith@inl.gov>
cc "Dante C Huntsman" <Dante.Huntsman@inl.gov>, "Robert L Sant" <Robert.Sant@inl.gov>, "Ashley Tull" <amt1@nrc.gov>, "Angela McIntosh" <ARM@nrc.gov>
Subject Fwd: Event 070024 -Label as Potential AO

Please mark as potential AO.
----- Message from "Angela McIntosh" <ARM@nrc.gov> on Fri, 22 Jun 2007 12:16:52 -0400 -----

To: "Michele Burgess" <MLB5@nrc.gov>
cc: "Ashley Tull" <amt1@nrc.gov>
Subject: Event 070024 -Label as Potential AO

Michele, Event 070024 was once labeled a potential AO in NMED, but is no longer labeled as such. The dose to the penile bulb, 11,000 rad, seems to clearly meet AO criteria C.1.b.2.(b)(iii). Furthermore, the licensee states that the magnitude of the dose to the penile bulb could result in scarring, fibrosis, erectile dysfunction, and impotency. (Sounds like permanent functional damage, although this has not been confirmed.)

Request this event be marked a potential AO. The abstract follows.

Thanks,
Angela

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NMED Item Number: 070024

Narrative: **Last Updated:** 05/02/2007

The licensee reported that an error occurred during a brachytherapy seed implant procedure, resulting in a dose less than prescribed to the intended site and doses greater than prescribed to unintended sites. The patient was prescribed a total dose of 12,000 cGy (rad) to the prostate using 41 I-125 seeds, with each seed containing 11.84 MBq (0.32 mCi). The patient moved after

two of the 14 treatment needles were inserted. The procedure was delayed to allow general anesthesia to take affect. The lineup was checked using ultrasound and once the urologist, radiation oncologist, and medical physicist were comfortable with the situation, the implant procedure was resumed. After the procedure was completed, radiographs revealed that 34 of the 41 seeds were inadvertently deposited 4 cm inferior to the prostate. As a result, the prostate received a dose of 1,300 cGy (rad). In addition, the penile bulb received approximately 11,000 cGy (rad), and the patient's skin received approximately 240 cGy (rad), more than 50% greater than prescribed. The dose to the penile bulb could result in scarring, fibrosis, erectile dysfunction, and impotency. The patient was notified of the error. This event was caused by the failure to have adequate procedures and a lack of communication. The NRC contracted a medical consultant, who concurred with the licensee's evaluation. Corrective actions included procedure revision.