Duane White
<Duane.White@nrc.gov>
10/29/2008 05:49 AM

To Dante C Huntsman <Dante.Huntsman@inl.gov>, Robert L Sant <Robert.Sant@inl.gov>
cc Thomas W Smith <Thomas.Smith@inl.gov>
bcc
Subject FW: Medical Event Presentation for ACMUI

In regards to the VA event record see email below. Please change the record accordingly.

Duane
(301) 415-6272

From: Sandra Gabriel
Sent: Friday, October 24, 2008 6:26 PM
To: Donna-Beth Howe
Cc: Duane White
Subject: RE: Medical Event Presentation for ACMUI

If someone questions this at ACMUI, please inform them of the correction. I have also informed the Region I person responsible for submission of information to NMED. Based on your suggestion, I'll also send this to Duane White. Thanks.

From: Donna-Beth Howe
Sent: Friday, October 24, 2008 6:23 PM
To: Sandra Gabriel
Subject: RE: Medical Event Presentation for ACMUI

Sandy,

Too late to get that one in writing. I won't be going into too much detail so it probably won't come up. I hope you sent the change to Duane White and NMED.

Donna-Beth

From: Sandra Gabriel
Sent: Friday, October 24, 2008 6:18 PM
To: Donna-Beth Howe
Subject: RE: Medical Event Presentation for ACMUI

Just realized another error. Every location that says "point B" should be "point A." Doses are for "right point A" and "left point A." thanks.

From: Sandra Gabriel
Sent: Thursday, October 23, 2008 11:15 AM
To: Donna-Beth Howe
Subject: RE: Medical Event Presentation for ACMUI

Here's the original report, with just the doses changed:

Bridgeport Hospital reported that two patients received underdoses during Cs-137

brachytherapy cervix treatments using a manual afterloader. The medical events were discovered on 5/7/2008. One patient was prescribed to receive **3001** and **2552** cGy (rad; right point A and left point B) on 12/10/2007, but was delivered **1256** and **1231** cGy (rad; right point A and left point B). On 1/2/2008, that patient was prescribed to receive **1887** and **2020** cGy (rad; right point A and left point B), but was delivered **1042** and **1116** cGy (rad; right point A and left point B). The second patient was prescribed to receive **2276** and **2672** cGy (rad; right point A and left point B) on 1/9/2008, but was delivered **948** and **1296** cGy (rad; right point A and left point B). On 1/30/2008, that patient was prescribed to receive **2292** and **2232** cGy (rad; right point A and left point B), but was delivered **876** and **988** cGy (rad; right point A and left point B). The cause was related to a change in the input made to the treatment planning computer involving the magnification factor. The patient's prescribing physician and oncologist have been informed and discussions are underway to determine future actions. The patients have not been informed.

Here's the overall update to the narrative that I am submitting today (bottom sections of the report will also need to be updated:

NMED Item Number: 080278

Narrative: Last Updated: 10/23/2008

Bridgeport Hospital reported that two patients received underdoses during Cs-137 manual brachytherapy treatments for cancer of the cervix. The medical events were discovered on 5/7/2008. One patient was prescribed to receive 3001 and 2552 cGy (rad; right point A and left point B) on 12/10/2007, but was delivered 1256 and 1231 cGy (rad; right point A and left point B). On 1/2/2008, that patient was prescribed to receive 1887 and 2020 cGy (rad; right point A and left point B), but was delivered 1042 and 1116 cGy (rad; right point A and left point B). The second patient was prescribed to receive 2276 and 2672 cGy (rad; right point A and left point B) on 1/9/2008, but was delivered 948 and 1296 cGy (rad; right point A and left point B). On 1/30/2008, that patient was prescribed to receive 2292 and 2232 cGy (rad; right point A and left point B), but was delivered 876 and 988 cGy (rad; right point A and left point B). The cause was human error involving incorrect implementation of a new method to input geometric data into the treatment planning computer. This resulted in use of an incorrect magnification factor in the dose calculations. The patient's referring physician and radiation oncologist were informed. The patients were informed and received additional treatment.

thank you!

p.s. It turns out that Region I submitted the erroneous data to NMED. The person who submitted it has been unable to identify how the error was introduced--the references he used all showed the correct units. The inspector was not given an opportunity to review

the data before submission to NMED.

From: Donna-Beth Howe
Sent: Thursday, October 23, 2008 10:59 AM
To: Sandra Gabriel
Subject: RE: Medical Event Presentation for ACMUI

Sandy

Just send me the correct information. If you can cut and paste with the correct information bolded it would be helpful.

Donna-Beth

From: Sandra Gabriel
Sent: Thursday, October 23, 2008 10:07 AM
To: Donna-Beth Howe
Subject: Medical Event Presentation for ACMUI

Hi Donna-Beth. Ashley sent me a copy of the E-binder for next week's meeting. I took a quick look at your medical events presentation. I was the inspector for Bridgeport Hospital, and the NMED report contains a huge error; looks like the contractor got confused with cGy vs Gy, therefore listing doses that are 100 times too large. I will notify NMED. Is there some way this can be fixed for ACMUI? Thanks.