Full Report

03/30/2011

Item Number: TX080032

Last Updated: 09/15/2009

Narrative:

I-8568, Overexposure to a Patient's Thyroid Gland, South
Texas Radiology Imaging Centers, L00325, September 2,
2008.

On September 2, 2008 a patient was referred to an out
patient imaging center and was mistakenly dosed with
3.8mCi of I-131 instead of 30mCi of Tc-99m for a routine
bone scan. In placing the order for a nuclear medicine
study, the referring physician's receptionist had first
checked "Bone Scan – Total Body" but then drew a line
through that entry and marked "I-131 Whole Body Scan".
Apparently the appropriateness of this study for the patient
was not verified by the referring physician, nuclear medicine
technologist or authorized physician user (APU). The error
was discovered 48 hours after the dose was administered
on September 4, 2008 when the patient returned to the
center for imaging. Because the dose was given in
accordance with a signed Written Directive, there was
some confusion as to whether this misadministration strictly met the
provisions of a Medical Event. Therefore, it was not until
today, October 2, 2008, at 1200hrs. when the Medical Event
was declared within 24 hours of an on-site inquiry
conducted by Agency staff. In the APU's Final Report it
was determined "that a total body scan with Technetium
was intended to be ordered". A licensed Medical Physicist
report estimates the dose to the thyroid as 4940 rem which
is identical to the value on the manufacturer's package
insert both having been derived from MIRD Dose Estimate
Report No. 5, Summary of Current Radiation Dose
Estimates to Humans from Sodium Iodide, Journal of
Nuclear Medicine 16:857-860, 1975. This Medical Event
exceeds Reporting Material Events - SA-300, Abnormal
Occurrence (AO) Criteria, Section IV, For Medical
Licensees where it states that A Medical Event that: (a)
Results in a dose…greater than 10Gy (1,000 rad) to any
organ; and (b)Represents…(2) a prescribed dose or
dosage that is the wrong radiopharmaceutical… A more
detailed report is being assembled as the investigation
continues.

12/29/08 RSO calls about question of NOV. Response already accepted for corrective action.
File closed

Event Date: 09/02/2008 **Discovery Date:** 09/04/2008 **Report Date:** 10/02/2008

Licensee/Reporting Party Information:

Name:	SOUTH TEXAS RADIOLOGY IMAGING CENTERS	License Number:	L00325
City:	SAN ANTONIO	State: TX	Zip Code: 78229

Site of Event:

Site Name:	Village Square Med. Bldg.	State:	TX

Additional Involved Party:

Name:	South Texas Radiology Imaging Centers	License Number:	L00325
City:	San Antonio	State: TX	Zip Code: 78229

Other Information:

Reportable Event:	Y	Reciprocity:	NONE
Atomic Energy Act Material:	Y	Abnormal Occurrence:	P
Investigation:	Y	Include in Transfer File:	Y
Consultant Hired:	N	Event Closed:	Y

Corrective Actions Information:

Action Number: Corrective Action:

MD2

1 PERSONNEL REPRIMANDED
2 PROCEDURE MODIFIED
3 PERSONNEL RECEIVED ADDITIONAL TRAINING

Patient Information:

Patient Number: 1

Patient Informed: Y Date Informed: 09/04/2008

Given:

Diagnostic Study: WHOLE BODY I-131/THYROID

Radiopharmaceutical: SODIUM IODIDE

Radionuclide: I-131 Activity: 3.8 mCi 140.6 MBq

Intended:

Diagnostic Study: BONE

Radiopharmaceutical: METHYLENE DIPHOSPHONATE

Radionuclide: TC-99M Activity: 25 mCi 925 MBq

% Dose Exceeds Prescribed: NA

% Dose is Less Than Prescribed: NA

Effect on Patient: UNKNOWN

Source of Radiation:

MD2

Source Number: 1

Source/Radioactive Material: UNSEALED SOURCE RADIOPHARM Radionuclide or Voltage (kVp/MeV): I-131

Manufacturer: Activity: 0.025 Ci 0.925 GBq

Model Number:

Serial Number:

Reporting Requirements:

MD2

Reporting Requirement: 35.3045 - notifications and reports of medical involving administration and use of byproduct marterial, with the exception of patient intervention events

Keywords:

MD2

RADIOPHARMACEUTICAL OVEREXPOSURE

References:

Reference Number:	Entry Date:	Retraction Date:	Coder Initials:	Reference Type:
TX I-8568	10/02/2008		DRJ	AGREEMENT STATE EVENT REPORT