

EVENT REPORT COVER PAGE

Agreement State

Texas Incident #: I - 8568

Event Report ID No: 44534

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NMED Projects

SUBJECT Significant Event Report (24-hour Notification)

STATE; Texas

Signature and Title Ray Jisha 512 834-6770 2015 Incident Investigator

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Inspection Unit

Radiation Branch

Environmental Program

Preliminary Not For Public Disclosure

Agreement State Agency TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Investigation Unit,
Radiation Branch

Texas Incident #: I - 8568
Event Report Number: 44534
License Number: L00325
Licensee: South TX Radiology Imaging Centers

Address : 4499 Medical Drive
City : SAN ANTONIO
Event Date: 9/2/2008
Date Received: 10/2/2008
Event Location Village Square Medical Bldg.
8601 Village Drive Ste 111
SAN ANTONIO
Texas

Event Type: 35.3045 notifications and reports of medical events involving administration and use of byproduct materials, with the exception of patient intervention events.

Notifications:

Transport vehicle description: N/A

Media attention: None

Point of contact: Ray Jisha 512 834-6770; ext. 2015

Description of Event 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.