Hospital	Event Number: 46224
Rep Org: PROVIDENCE HOSPITAL Licensee: PROVIDENCE HOSPITAL Region: 3 City: NOVI State: MI County: License #: 21-02802-03 Agreement: N Docket: NRC Notified By: VRINDA NARAYANA HQ OPS Officer: ERIC SIMPSON	Notification Date: 09/02/2010 Notification Time: 13:30 [ET] Event Date: 08/30/2010 Event Time: 14:00 [EDT] Last Update Date: 09/14/2010
Emergency Class: NON EMERGENCY 10 CFR Section: 35.3045(a)(1) - DOSE <> PRESCRIBED DOSAGE	Person (Organization): TAMARA BLOOMER (R3DO) ANGELA MCINTOSH (FSME)

Event Text

MISPLACED PALLIATIVE SOURCE IMPLANTS

On August 30, 2010, a patient was implanted with I-125 seeds in the anus for a palliative procedure. Two days later, September 1, 2010, a follow-up CT scan on the patient showed that the implants had been inserted 4 cm superior to the intended location which would lead to less dose at the target location. The intended dose was 90 Gy to the anus.

More imaging studies are planned to estimate the actual dose to the intended target area. The patient will be implanted again after the imaging study is complete. A decision will be made at that time whether to correct the original implants.

The reason for the error is believed to be twofold: The tumor had progressed markedly since the original planning and the decision was made to correct the plan for the additional growth based on palpation indications. Also, the 10 cm mark on the needle may have been mistaken for the 5 cm mark.

No long term complications are anticipated.

Both patient and physician have been informed.

* * * UPDATE AT 1330 EDT ON 09/14/10 FROM VRINDA NARAYANA TO S. SANDIN * * *

The licensee is updating this report to provide the results of the normal tissue doses from the permanent implants at the end of the treatment plan to the following organs:

Bladder: Prescribed .07 Gy - Delivered 3.75 Gy
Seminal Vesicles: Prescribed 5.38 Gy - Delivered 25.17 Gy
Prostate: Prescribed 6.24 Gy - Delivered 4.2 Gy
Rectum: Prescribed 45.18 Gy - Delivered 3.16 Gy

The above information will be provided in the 15-day written report. Notified R3DO (Hills) and FSME (Burgess).

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.