Hospital	Event Number: 42511
Rep Org: UNITED HOSPITAL CENTER Licensee: UNITED HOSPITAL CENTER Region: 1 City: CLARKSBURG State: WV County: License #: 4701458-01 Agreement: N Docket: NRC Notified By: JAMES ISRAEL - RSO HQ OPS Officer: JOHN KNOKE	Notification Date: 04/19/2006 Notification Time: 14:13 [ET] Event Date: 04/11/2006 Event Time: 11:40 [EDT] Last Update Date: 04/19/2006
Emergency Class: NON EMERGENCY 10 CFR Section: 35.3045(a)(3) - DOSE TO OTHER SITE > SPECIFIED LIMITS	Person (Organization): DANIEL HOLODY (R1) GREG MORELL (NMSS)

Event Text

MEDICAL EVENT - ADMINISTRATION OF GREATER THAN 50 PERCENT OF PRESCRIBED DOSE TO PATIENTS

The RSO of the United Hospital Center called about a misadministration to 2 female patients being treated for cervical cancer. Each patient was to receive a total of 3000 centigrays, distributed via 6 treatments of 500 centigrays each. The treatment was a high dose rate Brachytherapy insertion of a 4.4 Curie Ir-192 sealed source into the cervical area. On their first treatment, patient #1 received 1040 centigrays at 11:40 EDT on 04/11/06, and patient #2 received 1058 centigrays at 11:45 EDT on 4/18/06. The attending physician is now going to alter the remaining treatments to 350 centigrays/treatment for each patient, thereby keeping the original total dose to the required 3000 centigrays/patient.

The reason given for the misadministration was human error. The operator did not check the magnification reading on the computer before administrating the dose to each patient. The referring physician will be discussing this error with each patient when they come in for their next treatment on 4/21/06.