Hospital	Event Number: 45174
Rep Org: KARMANOS CANCER INSTITUTE Licensee: KARMANOS CANCER INSTITUTE Region: 3 City: DETROIT State: MI County: License #: 21-04127-06 Agreement: N Docket: NRC Notified By: JOE RAKOWSKI HQ OPS Officer: DONG HWA PARK	Notification Date: 06/30/2009 Notification Time: 10:33 [ET] Event Date: 02/18/2008 Event Time: 12:00 [EDT] Last Update Date: 06/30/2009
Emergency Class: NON EMERGENCY 10 CFR Section: 35.3045(a)(1) - DOSE <> PRESCRIBED DOSAGE	Person (Organization): DUNCAN WHITE (FSME) MONTE PHILLIPS (R3DO)

Event Text

MEDICAL EVENT INVOLVING A DOSE THAT IS DIFFERENT THAN PRESCRIBED

"On February 18, 2008, an administrative error medical event occurred at our Leksell Gamma Knife facility which resulted in the total dose delivered differing from the written directive by more than 20%, but which agreed with the therapy that was intended and planned by the radiation oncologist authorized user (AU) and the neurosurgeon. This was discovered during the 2008 annual quality management review that was completed on June 24, 2009.

"On February 18, 2008, a stereotactic radiosurgery treatment plan was developed by the neurosurgeon, AU and authorized medical physicist (AMP) that satisfied the therapy intentions of the AU and neurosurgeon. Two of the three metastatic lesions that were discussed in advance at the neurosurgery tumor board meeting on February 13, 2008 by the neurosurgeon and AU were treated, the third being geometrically out of range of the gamma knife system. Specifically, the lesion locations selected at the tumor board meeting were right cerebellum, right occipital lobe and left temporal/parietal. The left temporal/parietal was out of range. The correct intended dose of 20 Gy to 50% isodose was planned and delivered on February 18. The AU and AMP specified both lesions on the Gamma Knife planning QA form which was signed by the AU, Neurosurgeon and AMP. The AU signed the plan and initialed every page including screenshots of the isodoses superimposed on the MRI images for both lesions. The plan included all of the information required in 10 CFR 35.40 (b)(3). Finally, the time out form was completed by the AU, neurosurgeon and AMP.

"The administrative error medical event is the result of the AU not writing a directive for treatment of the right occipital lesion.

"[The event occurred due to] lack of attention to administrative tasks.

"[The individual who received the administration had] no detrimental effect. Treatment was delivered as planned according to doctor's orders.

"The gamma knife quality management review will be done on the day of treatment prior to delivery by a second physicist using the form/checklist attached. This process is already in effect."

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.