

Hospital	Event Number: 44733
Rep Org: TRINITAS HOSPITAL Licensee: TRINITAS HOSPITAL Region: 1 City: ELIZABETH State: NJ County: License #: 29-04333-01 Agreement: N Docket: NRC Notified By: LINDA VELDKAMP HQ OPS Officer: MARK ABRAMOVITZ	Notification Date: 12/18/2008 Notification Time: 17:41 [ET] Event Date: 12/17/2008 Event Time: 14:00 [EST] Last Update Date: 12/18/2008
Emergency Class: NON EMERGENCY 10 CFR Section: 35.3045(a)(1) - DOSE <> PRESCRIBED DOSAGE	Person (Organization): RICHARD BARKLEY (R1) JIM LUEHMAN (FSME)

### Event Text

#### MEDICAL DOSE LESS THAN 50 PERCENT OF PRESCRIBED DOSE

"Suspected movement of catheter during endobronchial high dose rate remote afterloading treatment procedure may have resulted in a single fraction of a multifraction treatment to differ from the prescribed dose by more than 50%. (35.3045 (1)(iii)).

"Both the patient and the referring physician were notified by the authorized user of the possibility the intended treatment site did not receive full dose.

- "1. Patient had endobronchial catheter placed in Rt Bronchus in the endoscopy department. Catheter was taped in place and position was marked.
- "2. Patient was scanned in CT simulation room by therapist to determine catheter location and treatment dwell positions.
- "3. Patient treatment plan was created by physicist and approved by the authorized user. Second calculation check was performed.
- "4. Patient was monitored by nursing during the treatment planning process.
- "5. Patient was brought into HDR treatment room by therapist.
- "6. Authorized physicist and authorized user connected the treatment applicator to the HDR unit.
- "7. Technologist monitored patient on the camera system.
- "8. Treatment was administered as planned.
- "9. Patient was disconnected from the HDR unit.
- "10. Technologist removed catheter post treatment, noted the catheter she pulled out was relatively short compared to the planning scan.
- "11. Technologist notified the authorized user and authorized physicist.
- "12. Both individuals notified the RSO.
- "13. RSO investigated and interviewed individuals involved.
- "14. AU not sure at what point the catheter moved.

"Patient may have dislodged catheter when coughing or wiping mouth secretions.

"Actions to prevent re-occurrence:

- "1. Authorized user will remove all endobronchial catheters post treatment in the future to prevent any ambiguity with regard to length of catheter in patient.
- "2. Check marked position of the catheter at CT and both pre and post treatment prior to catheter removal.
- "3. Measure catheter length outside the naries prior to planning CT, prior to treatment, and post treatment as a second check to the marked position.

"The Pulmonologist and Authorized user will perform a bronchoscopy in about 2 weeks [to determine if misadministration occurred]. Treatment reactions outside the planned treatment site will be evaluated and determination of treatment in an unintended area will be determined."

A Medical Event may indicate potential problems in a medical facilities use of radioactive materials. It does not necessarily result in harm to the patient.