01-04

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA

3400 Spruce Street/G1 Philadelphia, PA 19104 (215)662-4000

9 January 1981

USNRC
Office of Inspection and Enforcement
Region 1
631 Park Avenue
King of Prussia, PA 19406

RE: Quarterly Misadministration Report
Refer to 10CFR35, sections 35.41 & 35.45

Gentlemen:

The following is a report of a misadministration occurring in our facility during the last calendar quarter:

a) Licensee's name

Trustees of the University of Pennsylvania, 37-00118-07, with Radiaition Safety Office approval to Nuclear Medicine, Department of Radiology, Hospital of the University of Pennsylvania

b) Referring M.D. - Francine Fleegler, M.D.

c) Description of event - On 16 November 1980 a Nuclear Medicine technologist, required to inject 20 mCi of 99m-Tc methylene diphosphonate (MDP) for a bone scan, instead drew a dose of 15 mCi of 99m-Tc DTPA, a kidney scanning agent, and injected it into the patient. The technologist states subsequently that there was not sufficient attentiveness to the nature of the scan to be performed on the patient.

d) Effect on patient - None, except for unanticipated absorbed radiation dose from the 99m-Tc DTPA which was injected. The patient was scanned the following day with 20 mCi of 99m-Tc MDP.

e) Although this type of error occurs very infrequently, all our technologists were advised of the possibility of such occurrences and were specifically cautioned about being doubly attentive about the scan to be done, the material and quantity to be injected.

Sincerely yours,

Abass Alavi, M.D.
Chief, Division of Nuclear Medicine

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