

Radiology Associates 

ALBERT EINSTEIN MEDICAL CENTER
YORK AND TABOR ROADS, PHILADELPHIA, PA. 19141

April 3, 1979

Docket Nos. 30-07061
30-07551
30-10885

U.S. Nuclear Regulatory Commission
George H. Smith, Chief
Fuel Facility and Materials Safety Branch
Region 1
631 Park Avenue
King of Prussia, PA. 19406

Subject: Inspection 79-01

Dear Mr. Smith:

This is in answer to your letter dated March 20, 1979 and Notice of Violation for License Nos. 37-00448-17, 37-00448-19, 37-00448-20.

- A. 1. Procedures for the safe handling of radioactive materials were explained to the Southern Division Nuclear Medicine technician. A survey of the implementation of the procedures was carried out on March 28, 1979. No removable contamination was found on the hands, since disposable gloves are being utilized.
- 2. The procedure for collection of contaminated waste (swabs used in the injectable licensed material) has been changed. All swabs are to be placed in a special container and disposed of as "hot trash". All trash will be periodically monitored to insure compliance.
- B. Lead bricks were replaced in their proper configuration surrounding the radium sources in the safe in the "Radium Room". The levels outside the Radium Room are back to less than 2 mrem/hr. In addition to the lead bricks, it is our intent to deplete our radium supply in the near future by more than 100 mg. This will further reduce the dose rate.
- C. The Radiation Therapy Residents have been instructed in post-removal survey procedures and the need for documentation of such. All records of patients since the inspections are complete and will continue to be so.

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Radiology Division, Bernard J. Ostrum, M.D., Chairman

ROENTGEN DIAGNOSIS-455-8400

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RADIATION THERAPY-329-0700

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NUCLEAR MEDICINE-329-0700

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U.S. Nuclear Regulatory Commission
George H. Smith, Chief
Fuel Facility & Materials Safety Branch

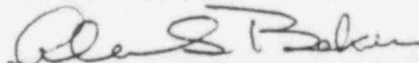
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- D. The leak testing of all the sealed sources was carried out on March 1, 1979 and will be carried out each six months henceforth.
- E. The Cardiologist's secretary had been instructed to follow-up all patients. This evidently did not operate properly. All follow-up records will now be fully maintained in the Radiation Safety Office. Of 10 original implants, three patients died, four were explanted. These seven pacemakers were returned to Biotroniks Corporation. One patient moved to Florida and care was transferred to Dr. James H. Cleary, Chief of Surgery, Veterans Administration Hospital, Bay Pines, Florida 33504. The 1978 and 1979 records are being sent to us. The two outstanding patients are being contacted at this time by the Cardiologist.

Thank you for your attention.

Sincerely yours,



Alan S. Baker, M.S.
Radiation Safety Officer

cc: Bernard Shapiro, M.D.
Martin Goldsmith, General Director
Michael Nunno, M.S.
Joseph Nussbaum, M.D.
Linda Albin, M.S.

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