## HARVARD MEDICAL SCHOOL





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Dear Sirs,

I wish to report a diagnostic misadministration of dose which occurred in the Nuclear Medicine Department of the Beth Israel Hospital on January 8, 1981.

A technologist called out a patient's name (patient A) in the outpatient waiting area shared with the Radiation Therapy Department. A Radiation Therapy patient (patient B) sitting with her daughter answered to the name. She was injected with 20mCi of Tc99m methylene diphosphonate, a bone scanning agent. The patient had repeatedly been addressed as patient A by the technologist during the explanation of the scanning procedure. The error was discovered a few minutes after injection when patient B's daughter complained to the receptionist that the technologist was calling her mother by the wrong name.

The attending physician, Dr. Ty Rich, a Radiation Therapist, was immediately notified, an incident report was filed, and the Radiation Safety Officer was notified.

The estimated absorbed radiation dose from the intravenous injection of 20mCi of Tc99m methylene diphosphonate as described in the radiopharmaceutical's package insert (Osteolite, New England Nuclear) is as follows:

ORGAN	Rads/20mCi
Total Body	0.13
Bone Total	0.70
Red Marrow	0.56
Kidneys	0.62
Liver	0.16
Bladder (2 hr. void)	2.60
Ovaries (2 hr void)	0.24

This dose is minimal when compared with the radiation dose the patient had received from the Radiation Therapy treatment. The following procedure has been instituted to identify out atients and prevent a reoccurrence of this incident: All outpatients are registered by the receptionist for billing purposes before they are seen by a technologist. At the time of registration, the receptionist fills out a card with the patient's name and the procedure he is to have. The patient hands this card to the technologist prior to injection.

Sincerely,

Rosemary Kennedy Radiation Safety Officer, Department of Radiology

Beth Israel Hospital