DCS No: 03007854011790
Date: January 18, 1990

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE--PNO-I-90-05

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region I staff on this date.

Facility: 37-06575-03
Monongahela Valley Hospital
Country Club Road
Carroll Township
Monongahela, Pennsylvania 15063

Licensee Emergency Classification:
____ Notification of Unusual Event
____ Alert
____ Site Area Emergency
____ General Emergency
__X__ Not Applicable

Docket No. 030-07854

Subject: MALFUNCTION OF SOURCE TRANSFER TUBE IN A REMOTE AFTERLOADING BRACHYTHERAPY IRRADIATOR (RABI)

On January 17, 1990, at 3:15 p.m. the licensee informed Region I of a disconnect between one of the source transfer tubes of a CIS-US Curietron 2E1000 afterloader and the patient applicator in a vaginal carcinoma treatment. For this treatment, the brachytherapy applicators are surgically inserted into the patient prior to insertion of the cesium-137 sources and extend a few inches outside the patient's body. The sources, connected to guide wires, are contained in a remote storage unit. Guide tubes from this storage unit connect to the applicator with a screw knob. The sources are then remotely transferred to the patient applicator through the guide tubes. The treatment began at 5:10 p.m. on January 16, 1990. The disconnect was identified during a routine check of the patient at 9:30 a.m. on January 17. The disconnect resulted in the placement of a 25 millicurie cesium-137 source outside of its intended location in the applicator within the patient. The transfer tube was replaced with another and the patient therapy continued. The licensee has calculated a worst case discrepancy between the prescribed and the delivered dose of 5.9 percent and is evaluating the dose received to the non-target tissue. The U.S. distributor of the RABI was notified and all the transfer tubes will be sent back to the manufacturer for analysis. First inspection of the transfer tube that became disconnected indicated a possible problem with the tube-applicator knob.

The licensee's corrective actions include a requirement for nursing personnel to check the tube applicator set-up with each treatment interrupt.

NRC Region I staff will continue to review the circumstances of the incident for potential generic safety implications. This information is current as of 10:30 a.m. on January 18.

CONTACT: J. Piccone 215-337-5169
M. Shanbaky 215-337-5209

2.15
IE-34

DCS No: 03007854011790
Date: January 18, 1990

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE--PNO-I-90-05

DISTRIBUTION:

OWFN	MNBB	L-St.	NL	Mail:	ADM:DMB
Chairman Carr	AEOD		RES		DOT:Trans only
Comm. Roberts	IRM	PDR			
Comm. Rogers	OIG			NRC Ops Ctr _____	
Comm. Curtiss					
Comm. Remick					

CA	EDO	Phillips	INPO----	
OGC	NMSS	ACRS	NSAC----	
GPA	NRR			
PA	OE	Regional Offices _____		
	SLITP		RI Resident Office _____	
		EWW		
		ASLAP	Licensee: _____	
			(Reactor Licensees)	