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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 III staff on this date.

Facility: University of Wisconsin- Madison Madison, Wisconsin	Licensee Emergency Classification: ___ Unusual Event ___ Alert ___ Site Area Emergency ___ General Emergency <u> x </u> Not Applicable
License No. 48-09843-18	

Subject: THERAPEUTIC MISADMINISTRATION

On February 8, 1990, the licensee reported that a 42-year old female patient undergoing treatment for vaginal cancer received a dose of radiation 27% higher than that prescribed.

The patient was to receive a total of four 1620-rad exposures (two each to the left and two each to the right side of the vaginal cavity or a total of 3240 rads to each side) using a 7-curie, iridium-192 brachytherapy implant. The implant was inserted into the cavity via a Microselector device manufactured by Nucletron. The device is computer controlled.

On February 7, 1990, during the second exposure to the right side, erroneous information was used in the treatment distance data fed into the Nucletron device. This resulted in a single dose of 2500 rads to the right side of the cavity and a total to this side of 4120 rads versus 3240 rads prescribed. The miscalculation was quickly discovered and a revised prescription was administered to the left side.

The licensee will submit a written report to Region III (Chicago) within 15 days. Region III will send an inspector to the hospital to review the incident. An NRC medical consultant also will be contracted to determine the medical significance of the misadministration.

The State of Wisconsin will be notified.

Region III was first informed of the event at 10:00 a.m. (CST), February 8, 1990. This information is current as of 12:15 p.m. (CST), February 9, 1990.

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*Denotes a Displaywriter/PC not an IBM 5520 Terminal.