A Teaching Hospital for Tufts Medical School

617 964-2800
Newton-Wellesley Hospital
Newton Lower Falls,
Massachusetts 02162

July 10, 1981

Region I - USNRC
Office of Inspection and Enforcement
631 Park Avenue
King of Prussia, Pennsylvania 19406

Gentlemen:

We are reporting a diagnostic misadministration of a radiopharmaceutical as required under 10-CFR part 35.43. This occurred under NRC license 20-02615-01, Newton-Wellesley Hospital licensee on May 22, 1981.

Dr. Lawrence Geuss, the patient's attending physician, requested a bone scan. 18mCi of Technetium 99m M.D.P. was to have been administered intravenously to the patient. The Nuclear Medicine technologist drew up 18mCi of Technetium 99m - TCHIDA, (prepared from a Union Carbide Kit), and this dose was intravenously injected. The patient returned two hours later for the imaging study and the radioactive material was seen to be in the gallbladder and biliary tract, rather than in the bone. A radiologist informed the patient. The Associate Chief radiologist and section head of Nuclear Medicine informed the referring physician and also discussed the incident with the patient. The patient was subsequently seen by one of the individual users on the license on May 29, 1981, who reported no obvious untoward effect to the patient. To prevent recurrence of such a misadministration, the technologists were re-informed to use more caution in checking the labels and all lead shields containing radiopharmaceuticals will have appropriate labeling and additional color coding according to the specific compound.

The patient's referring physician has been sent a letter documenting this misadministration. Records of this misadministration, as required, are in our files for your inspection.

Sincerely,

William C. Christenson
Executive Director

WCC/rc