Date: July 22, 1993

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PN39345

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:
X-Ray Treatment Center
East Point, Michigan

License No. 21-19575-01

Licensee Emergency Classification
____General Emergency
____Site Area Emergency
____Alert
____Unusual Event
_X_ N/A

Subject: THERAPEUTIC MISADMINISTRATION

On July 13, 1993, a 92-year-old patient began a series of radiation treatments to the leg using a cobalt-60 teletherapy device. The teletherapy treatments were preceded by eight treatments with a linear accelerator.

The treatment plan called for a total of 6,000 rads (60 Gy) via eight linear accelerator treatments of 200 rads (2 Gy) each and 22 treatments of 200 rads (2 Gy) each with the cobalt-60 teletherapy device. Each treatment involved two oblique wedged fields of 7 cm x 15 cm, that required the insertion of the wedges, devices used to modify the radiation beam to produce the desired dose pattern.

On July 20, 1993, the licensee discovered that all eight linear accelerator treatments and three of the four completed cobalt-60 teletherapy treatments had been performed without the use of the wedges.

As a result, the licensee calculated that the actual dose delivered in the linear accelerator treatments was 2,488 rads (24.88 Gy) instead of the intended 1,600 rads (16 Gy). The three teletherapy treatments performed without the oblique field wedges delivered 395 rads (3.95 Gy) instead of the intended 200 rads (2 Gy) per treatment. The first treatment in the series, which was performed under the direct supervision of the treating physician, used the wedges and delivered the intended dose.

The licensee indicated that the treatment plan was being revised to accommodate the higher than intended doses of the treatments without the wedges. The licensee does not expect any adverse effects to the patient.

An NRC medical consultant will evaluate the medical aspects of the misadministration, and Region III (Chicago) will conduct a special inspection to review the circumstances surrounding the case.

The State of Michigan will be notified. The information in this preliminary notification has been reviewed with licensee management.

Region III was notified of the misadministration by the licensee at 1:15 p.m. on July 21, 1993. This information is current as of 3 p.m. on July 22, 1993.

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