September 21, 1990

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-90-32

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 IV staff on this date.

FACILITY: Muskogee Regional Medical Center
LICENSE: 35-13157-02
DOCKET: 030-11571

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

SUBJECT: THERAPEUTIC MISADMINISTRATION

On September 19, 1990, the licensee reported that a patient received a therapeutic radiation dose to a portion of the right side of her neck that was not intended for treatment. This notice supplements the initial report of the incident, provided by Region IV on September 20, 1990, with information obtained during a discussion between Region IV staff and licensee representatives on September 21, 1990. The incident has subsequently been categorized as a therapeutic misadministration.

The patient had previously received a series of cobalt-60 teletherapy treatments totalling approximately 5500 rads to both the left and right cervical lymph node regions between December 11, 1989, and January 19, 1990. Treatment was discontinued in January; however, the oncologist prescribed that an additional dose of 2000 rads be given to the left posterior cervical lymph nodes 1 month later. During the simulation, the patient was placed in a prone (rather than the routine supine) position, and the right cervical region was tattooed, photographed, and radiographed rather that the left. The physician did not detect the error at the time, approved the simulation film, and treatment was completed (2000 rads) on the patient's right side.

The error was not detected until September 6, 1990, although the patient had returned for observation monthly after completion of the therapy on March 12, 1990. During the physical examination on September 6, the physician palpated an enlarged lymph node on the patient's left side, which prompted him to review the initial and second treatment schedules and led to his identification of the error. The prescribing oncologist, also the physician who provided followup observation in this case, was not available for comment at the time of this report.

The licensee plans to have a written report of the incident available for NRC review by September 24, 1990. Region IV plans to conduct an investigation at the licensee's facility the week of October 1, 1990, when the oncologist will be available for interview.

The licensee has not issued a press release, informed the news media, or responded to news media inquiries. Neither the licensee nor the NRC plans to issue a press release at this time.

RIV:DD:DRSS
ABBeach/ch
9/21/90

RA
RDMartin
9/21/90

IE34
0/1

The state of Oklahoma has been informed.

Region IV received notification of this occurrence by telephone from the licensee on September 19, 1990. Region IV has informed PA.

This information has been confirmed with a licensee representative.

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