04-15030-01

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE--PNO-V-90-48A Date: Dec. , 1990

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

FACILITY: Veterans Administration Medical Center
3350 La Jolla Village Drive
San Diego, California
License No. 04-15030-01

Docket No. 030-08456

Emergency Classification
___Notification of Unusual Event
___Alert
___Site Area Emergency
___General Emergency
_X_Not Applicable

SUBJECT: DIAGNOSTIC MISADMINISTRATION (UPDATE)

Revised information concerning the medical diagnostic misadministration incident of November 26, 1990, indicated the Technetium 99m pertechnetate dose administered to the patient was between 168 and 192 millicuries. This range is due to varying estimates of the time the physician took to finish administering the entire dose to the patient and the time at which the administration began. Using MIRD dose assessment methods, the licensee calculated the dose to the patient's thyroid to be 40 rads, 2.7 rads exposure to the bladder, and 2.5 rads to the whole body.

The licensee has also informed the Region V staff that the physician who erroneously administered the Technetium to the patient over approximately 25 minutes, was holding the injection syringe in his hands with no shielding. The licensee has estimated the dose to the physician's hands at 40 rads. The whole body dose estimate and film badge evaluation are pending.

This Preliminary Notification is issued for information only and is current as of 9:00 AM, (PST), December 4, 1990.

CONTACT: Robert J. Pate, RV (FTS 463-3752) or Jim Montgomery, RV (FTS 463-3778)

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