PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-III-94-35

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	Licensee Emergency Classification
Memorial Hospital	General Emergency
South Bend, Indiana	Site Area Emergency
	Alert
License No. 13-18881-01	Unusual Event
	X Not Applicable

Subject: MISADMINISTRATION DUE TO DISLODGED RADIOACTIVE SOURCE

An NRC Region III (Chicago) routine inspection at the licensee's facility on May 4, 1994, revealed that on April 13, 1992, a patient who had undergone radiation therapy for cervical cancer received an unintended radiation skin dose to the thigh and an eight percent underdose of the prescribed treatment during the first of two treatments, due to a dislodged cesium-137 implant source.

The patient's written prescription called for 3000 rads (3,000 centigray) equally distributed over two treatments. During the first treatment on April 13, 1992, a 44 millicurie cesium-137 sealed source dropped unobserved onto the patient's bed while it was being afterloaded into the brachytherapy applicator previously positioned in the patient. Four other cesium-137 sources used in the treatment were appropriately loaded into the applicator. It is believed that the misplaced source remained in close proximity to the patient's upper thigh for about seven hours, before it was discovered on the floor of the patient's room by a nurse. The misplaced source was subsequently implanted and the treatment continued as planned.

According to the licensee, the prescribed treatment point to the patient's cervix received 1383 rads (1383 centigray) during the first treatment, about eight percent less than the intended dose. The licensee subsequently administered 1617 rads (1617 centigray) to the prescribed point of the cervix during the second and final treatment administered on April 27, 1992. At the time, the licensee did not consider the incident to represent a misadministration because the dose delivered to the cervix coincided with what was prescribed. The licensee estimates that the upper thigh of the patient received a dose of 1034 rads (1034 centigray), as a result of the misplaced source.

The licensee did not observe any adverse effects to the patient shortly after the incident. Additional medical follow-up of the patient is planned by the licensee. The licensee is attempting to notify the referring physician of the misadministration and a determination will be made, based on medical judgement, whether the patient will be notified.

Region III (Chicago) will retain an NRC medical consultant to review this case.

The State of Indiana and NMSS have been notified. The information in this preliminary notification has been reviewed with licensee management.

Region III was notified of the misadministration at 4:45 p.m. (CDT) on May 5, 1994. This information is current as of 10:00 a.m. (CDT) on May 6, 1994.

CONTACT:

Wayne Slawinski
(708) 829-9820

Roy Caniano
(708) 829-9836

110003