PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-III-91-03 Date January 24, 1991

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: Hutzel Hospital
Detroit, Michigan
03002084
License No. 21-03001-01

Licensee Emergency Classification
General Emergency____ Site Area Emergency____
Alert____ Unusual Event____ N/A__X__

Subject: DIAGNOSTIC MISADMINISTRATION WITH DOSE IN THERAPEUTIC RANGE

On January 16, 1991, a 37-year-old female patient received a 5 millicurie dose of iodine-131 instead of the prescribed dose of 500 microcuries. The intended diagnostic procedure was to evaluate a patient for a mediastinum mass. The nuclear medicine technologist administering the procedure questioned the incoming requisition and contacted the referring physician's assistant. The assistant, who is not a licensed physician, indicated that he thought that the referring physician wanted an alternate thyroid evaluation involving the administration of 5 millicuries. The 5 millicuries dosage was subsequently administered. The referring physician, however, subsequently indicated he did not desire the alternate study and resulting higher dose.

The licensee has estimated that the patient's thyroid received a radiation exposure of approximately 5,000 rads. This dosage is in the range of a therapeutic dose.

The patient had given birth to a baby two days before the procedure, but she is not breast feeding the infant. The licensee has restricted the patient from any contact with the baby to preclude unnecessary radiation exposure. This restriction will continue until radiation levels have decreased to background levels.

The licensee has revised its procedures to require written approvals by an authorized user just prior to iodine-131 oral administrations. It has also consulted an endocrinologist for evaluation of the effects of the misadministration. The licensee is evaluating the performance of individuals involved in this event.

DISTRIBUTION:

HEADQUARTERS OFFICES		REGIONS	MAIL TO:
Chairman Carr	NMSS	Region I	DCS (Orig)
Comm. Rogers	GPA:SP	Region II	DOT (Trans.
Comm. Curtiss	GPA:PA	Region IV	Only)
Comm. Remick	GPA:CA	Region V	
EDO	*OIG		
Gen. Counsel	*ASLAP	FAX TO:	
NRR	Research	INPO ____ NSAC ____ LIC ____	
AEOD	IRM	NRC OPS CTR 4:41	
Enforcement	ACRS	PDR (8/634-3343) 4:42	

*Denotes a Displaywriter/PC not an IBM 5520 Terminal.

Rev. 10/23/90

Region III (Chicago) will conduct a special inspection to review the circumstances of the misadministration. An NRC medical consultant has been retained to evaluate the case.

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

Region III received initial notification of this misadministration at 3:30 p.m. on January 23, 1991. Additional information was obtained from the licensee on January 24, 1991. This information is current as of 1:30 p.m. on January 24, 1991.

CONTACT: R. Caniano 388-5721
J. Grobe 388-5612