228

DCS misadministration (CF available)

ST. JOSEPH'S HOSPITAL

611 ST. JOSEPH AVENUE, MARSHFIELD, WI 54449

July 9, 1981

Nuclear Regulatory Commission, Region III
Radioisotopes Licensing Branch
799 Roosevelt Road
Glen Ellyn, IL 60137

Gentlemen:

In compliance with 10 CFR 35.43, we hereby report the following diagnostic misadministration occurring under our byproduct license #48-10966-03, Marshfield Clinic, St. Joseph's Hospital, Marshfield Medical Foundation license.

This report is a copy of the report in our file with the patient's name and technologist's name omitted. The patient was informed at the time of the scan and his referring physician was informed that day.

The complete report is on file in the Radiation Safety Office.

Sincerely,

Ms. Lois J. Rutz, M.S.
Radiation Safety Officer

Enclosure

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XA Copy Has Been Sent to PDR

JUL 13 1981

XA
8108210490 810709
NMS LIC30
48-10966-03

Misadministration of Diagnostic Dose of Radiopharmaceutical

June 22, 1981

A. Patient's name and Social Security number:

B. Name of all individuals involved in the event:

C. Brief Description of what happened:

Dr. requested liver scan to aid in evaluation of a patient with carcinoma of the prostate. When the request was transposed from the order sheet to the Nuclear Medicine request sheet, an error occurred and brain scan was requested. The patient was therefore injected with technetium-DTPA to perform the brain scan. A dose of 19.9 mCi being administered. Upon further review, it became apparent that a liver scan was desired.

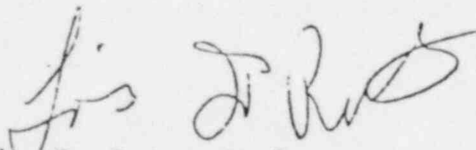
D. The effect on the patient:

No adverse effect.

E. Referring physician's name:

F. Action taken to remedy problem:

Nuclear Medicine technologists are now double-checking all scan orders prior to injection.

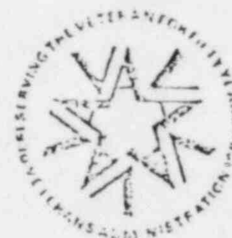


Lois J. Rutz, M.S.
Radiation Safety Officer

vjd

William S. Middleton Memorial Veterans' Hospital
2500 Overlook Terrace
Madison, WI 53705

Veterans Administration



September 18, 1981

Director, Nuclear Medicine (115)
Veterans Administration Central Office
Washington, DC 20420

SUBJ: Report to NRC Regional Office Regarding a Diagnostic Misadministration

1. Please find enclosed our report to the Nuclear Regulatory Commission Regional Office which is due October 10, 1981, regarding a diagnostic misadministration which occurred in our Nuclear Medicine Service on August 21, 1981.

2. Please forward this report to the Nuclear Regulatory Commission, Region III Office, in the enclosed envelope.

T. J. STRANOVA
Hospital Director

Enclosures (2)

RECEIVED

JAMES J. SMITH, M. D. (115)
Director, Nuclear Medicine Service
VA Central Office
Washington, D.C. 20420

In Reply Refer To

OCT 1 1981