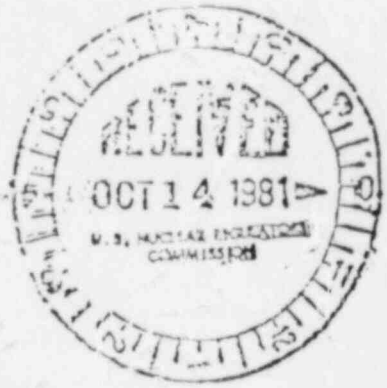
misadministration

St. Marys Hospital Medical Center

707 South Mills Street
Madison, Wisconsin 53715
Telephone (608) 251-6100

IE 259

October 5, 1981



United States Nuclear Regulatory Commission
Region III
799 Roosevelt Rd.
Glen Ellyn, IL 60137

Dear Sir:

This letter is being sent to inform you of a diagnostic radiopharmacentical misadministration at St. Marys Hospital Medical Center in Madison, Wisconsin, NRC License #48-00919-03.

On August 28, 1981 the Nuclear Medicine Department received two requests to do a Liver and Spleen Image and a Bone Image on one of Dr. [ ] patients. The Bone Image was performed on Friday, August 28 and the Liver and Spleen Image was scheduled for Monday, August 31. Due to a bookkeeping error made in the Nuclear Medicine Department, the patient was rescheduled for a Bone Image on August 31 instead of a Liver and Spleen Image. As a result of the error, the patient was injected with 16.1 mCi of ^{99m}Technetium MDP for a Bone Image instead of ^{99m}Technetium Sulfur Colloid for a Liver and Spleen Image.

At this point the appropriate nursing floor and Dr. [ ] were notified. A limited repeat Bone Image was performed and the patient was transported to his room with no apparent side effects. The Liver and Spleen Image was performed at a later date.

In an effort to prevent this type of bookkeeping error in the future, a meeting was held and all Nuclear Medicine personnel reviewed the department's bookkeeping procedures.

Sincerely,

Richard D. Lindgren, M.D.
Radiation Safety Officer

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