DCS No: 03001265940517
Date: May 20, 1994

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PN1-9433

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 I staff on this date.

Facility:
Stamford Hospital
P. O. Box 9317 - Shelburne Road
Stamford, Connecticut 06904-9317

Licensee Emergency Classification:
____ Notification of Unusual Event
____ Alert
____ Site Area Emergency
____ General Emergency
__X__ Not Applicable

Docket No.: 030-01265
License No.: 06-06697-02
Event No.: 27273
Event Location Code: HOS

SUBJECT: MEDICAL MISADMINISTRATION OF AN IODINE-131 DOSE

On May 19, 1994, the licensee notified the NRC Operations Center that on May 17, 1994, a patient was administered a 1 millicurie dose of iodine-131 sodium iodide for a whole body scan when no such study was prescribed. The licensee stated that a staff physician contacted the patient's health maintenance organization (HMO) on behalf of the patient in order to get approval for an in vitro laboratory study. The physician requested that the HMO schedule the patient for a "whole red cell mass test". The licensee stated that this test is performed on a sample of the patient's blood using a small quantity of chromium-51. According to the licensee, the HMO called the licensee's Nuclear Medicine Department and requested a "whole red cell mass test". Because the scheduling clerk was not familiar with this study, she reportedly asked the HMO if they meant a "whole body". The HMO replied in the affirmative and transmitted an order to the Nuclear Medicine Department for a "whole red cell mass test". The physician, an authorized user on the license, approved this order. The licensee stated that the scheduling clerk believed that the request was for a whole body iodine-131 scan and this study was placed on the schedule. On May 17th, the patient arrived for the study and a Nuclear Medicine Technologist administered the iodine-131 dose. The licensee stated that the Technologist did not adequately review the physician's order but instead relied on the information placed on the schedule by the scheduling clerk.

The licensee identified the error on May 18th when a radiologist reviewed the patient's scan and noticed the iodine-131 localization in the patient's thyroid. The licensee notified the patient's physician by phone on May 18th and met with the patient's physician on May 19th. The licensee stated that the patient's physician notified the patient of the misadministration on May 19th. The licensee estimated that the patient received a whole body dose of 470 millirem and a thyroid dose of 800 rads. The licensee is preparing a report of the misadministration for submission to the NRC. The NRC will schedule a special inspection to review the misadministration and will enlist the services of a medical consultant to evaluate the clinical consequences of the misadministration.

The State of Connecticut has been notified by the NRC. The Region I Office of Public Affairs is prepared to respond to media inquiries.

This information is current as of 1:00 p.m. on May 20, 1994.

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Contact: James P. Dwyer (610) 337-5309
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