PUBLIC

CONVERSATION RECORD

Time: 9:00 am

Date: 4/14/94

Contact	Organization	Phone No.
S. Shah, Ph.D.	Welborn Baptist Hospital	812-474-1110

13-01624-01

Summary

Background:

On April 6, 1994, at VA Hines, a patient being treated for cancer of the larynx was scheduled to receive the first of two radiation treatments using a GammaMed IIi HDR. Each treatment was to deliver a dose of 6 Gy, for a total dose of 12 Gy. Some time before the treatment, the radiation therapist correctly entered the treatment parameters into the GammaMed computer. The entry of these parameters was checked by another therapist and a radiation physicist. This check was documented on the licensee's HDR treatment form. At the time of the treatment, the therapist recalled the treatment parameters from the computer, and, by mistake, entered the date in the incorrect format, i.e., 040694 (June 4, 1994) rather than 060494 (April 6, 1994). She then checked the dwell times for each position, which were correct, and started the treatment. During the post-treatment quality assurance check, it was discovered that the treatment time was too long by a factor of 1.74. Further checking revealed that the date had been entered incorrectly, as discussed above, and this explained the long treatment time. This resulted in the patient receiving a dose of 10.4 Gy instead of the intended 6 Gy.

I informed Dr. Shah of this incident (without the specifics). He replied that their HDR was modified some time ago to add a computer chip which keeps time. This chip is used to check the date entered into the computer by the operator. Thus, an incident similar to that described above could not occur.

Action

None required.

Name	Signature	Date
Michael F. Weber	Michael F. Weber	4/14/94

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