Mercy Medical Center

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December 23, 1981

United States Nuclear Regulatory Commission
Region 3
799 Roosevelt Road
Glen Ellyn, Illinois 60137

Gentlemen:

The following is a report of an incident which took place at our institution on August 24, 1981.

A vial of DTPA was mislabeled as MDP. As a result a total of three doses were drawn, and three patients were injected with DTPA who where to have had bone scans. Upon imaging the first of the three patients it was noted that the radiopharmaceutical was tracing the kidneys. The vial was then checked and the error was discovered.

All three patients received approximately 20 mCi, the normal dosage alloted for renal imaging. The patients suffered no ill effects. A report of the error was filed with the patient chart and the Hospital Nuclear Medicine Committee. The bones scans, as ordered, were completed the following day.

Action has been taken to ensure that an error of this nature will not occur in the future. The action is outlined below:

1. All radiopharmaceutical kits are labeled in bold lettering upon receipt.

2. Lead shields are colored coded for specific by-products.

3. All vials are rechecked prior to preparing a dose for injection.

Sincerely,

Thomas J. Grunwald

Thomas J. Grunwald
Technical Director - Radiological Imaging

TJG/mj

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