

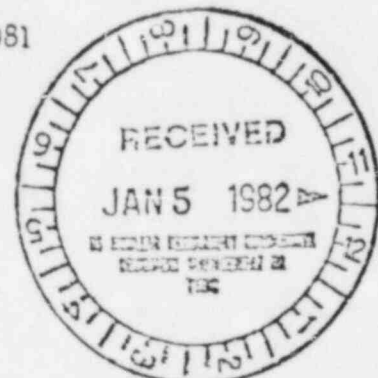


ST ELIZABETH HOSPITAL - A Member of United Health Services Inc

357723

December 22, 1981

United States Nuclear Regulatory Commission  
Region III  
Office of Inspection and Enforcement  
799 Roosevelt Road  
Glen Ellyn, Illinois 60137



Gentlemen:

On December 19, 1981, a diagnostic misadministration of 4.8 mCi of Tc-99m (MAA) was given to a patient for a lung scan. The desired isotope was Tc-99m but it was intended to be given as sulfur colloid for a liver-spleen scan. The desired liver-spleen scan using 5.0 mCi of Tc-99m in sulfur colloid was performed the following day.

The explanation for this incorrect procedure appears to be that certain individuals did not follow routine procedures. The referring physician prescribed a "L/S scan" which was misinterpreted as a lung scan by the nursing staff writing the Nuclear Medicine requisition. "L/S scan" is not accepted medical terminology for prescribing a liver/spleen scan and the nursing staff should not have interpreted this statement as a lung scan. The material was administered according to the order received by the Nuclear Medicine Department. Individuals responsible for this error were informed about this situation to prevent a recurrence. Procedures for ordering Nuclear Medicine exams appear to be satisfactory and no changes seem to be needed at this time.

Consultation with the referring physician found no clinically detectable adverse effect and none is anticipated in the future from the additional 4.8 mCi of Tc-99m (MAA).

This communication is written in accordance with 10 CFR Part 35 (35.43, Reports of diagnostic misadministrations). If additional information is required, please contact St. Elizabeth Hospital.

Licensee's Name: St. Elizabeth Hospital (#48-10219-01)  
Appleton, WI 54911

Referring Physician: [ ]

Sincerely,

*Stanley A. Reed*  
Stanley A. Reed, M.S.  
Medical Physicist

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**XA Copy Has Been Sent to PDR**

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