Wisconsin State Journal

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FREEDOM OF INFORMATION ACT REQUEST
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U.S. Nuclear Regulatory Commission
Office of Administration
Washington, D.C. 20555

To the FOI Officer:

This request is made under the federal Freedom of Information Act, 5 U.S.C. 552.

Please send me copies of medical misadministration reports to the NRC from hospitals licensed in Wisconsin. I would like copies of reports submitted during the period from January 1981 through December 1982. Some of these reports were summarized in a report prepared by the Office for Analysis and Evaluation of Operational Data, dated November, 1982, and authored by Samuel L. Pettijohn. The report was numbered: AEOD/M2043. Mr. Pettijohn's phone number is 301-492-4503. These reports were the subject of an article published in The Wisconsin State Journal on Jan. 30, 1983 (see attached). I would like copies of both diagnostic and therapeutic misadministrations in Wisconsin hospitals.

As you know, the FOI Act provides that if portions of a document are exempt from release, the remainder must be segregated and disclosed. Therefore, I will expect you to send me all nonexempt portions of the records I have requested, and ask that you justify any deletions by reference to specific exemptions of the FOI Act. I reserve the right to appeal your decision to withhold any materials.

I promise to pay reasonable search and duplication fees in connection with this request. However, if you estimate that the total fees will exceed $30, please notify me so that I may authorize expenditure of a greater amount.

As I am making this request in the capacity of a newspaper reporter, and this information is of timely value, I will appreciate your communicating with me by telephone, rather than by mail, if you have any questions regarding this request. Thank you for your assistance, and I will look forward to receiving your reply within 10 business days, as required by law.

Sincerely,

David Stoeffler

David Stoeffler
(608) 252-6135

NRC eyes nuke medicine misuse

By David Stoeffler
Environmental reporter

Concerns about nuclear power plants may get the headlines, but a recent federal report suggests that Wisconsin residents should turn some attention to mishandling of radioactive medicines by state hospitals.

A recent Nuclear Regulatory Commission report — encompassing medical uses of radiation at some 2,200 medical centers nationwide — indicates that hospitals sometimes use the wrong dose or the wrong drug when diagnosing or treating patients; that is, when they don't have the wrong patient.

At least 37 patients in Wisconsin hospitals were treated incorrectly during the period between Jan. 1, 1981, and June 30, 1982, the report said. That included one in-state patient given an inaccurate therapeutic dose of radioactive iodine.

More than 800 patients nationwide were given wrong treatments during the same period.

While the NRC said this represents less than one in every 100 patients, the agency report indicated concern about personnel errors and mislabeling of radioactive drugs.

Nearly 30 percent of the mistakes involved administration to the wrong patient, often because a patient answered to the wrong name.

The report does not list mistakes by individual hospitals. However, Russell Marabito, an NRC spokesman in Chicago, said that none of the nearly 115 licensed hospitals in Wisconsin have been fined or reprimanded during the last two years for misuse of medicines.

All of Madison's hospitals have nuclear medicine departments.

Most of the mistakes reported involved the use of radioactive medicines for diagnosing patients. In diagnosis, a radioactive material may be given to a patient as a tracer. X-rays of where the material collected could show various problems or tumors.

Of the treatment mistakes, 14 involved radioactive therapy, such as the use of iodine isotopes for thyroids or cobalt radiation for breast or brain cancer. One of those therapy errors involved a Wisconsin hospital.

In that case, a patient was to receive a capsule of radioactive iodine with a dose of 5.4 millicuries. Instead, a capsule with just 0.392 millicuries of radioactivity was administered.

The capsule given was supposed to have been thrown away, but was being kept in storage while its radioactivity decayed.

As a result, the patient needed a new dose of iodine, meaning the patient received more radiation than was necessary.

Therapy mistakes at licensed hospitals in other states included:

- Giving a dose of radioactive iodine to the wrong patient. The woman, who did not speak English, was misidentified. A language barrier was cited by the hospital, even though the patient was accompanied by an interpreter.
- Allowing a radiation source to slip undetected from an applicator used in treatment of cancer of the cervix. The source was later found in the patient's bed. About four weeks later, a small lesion appeared on the woman's buttock.
- Causing soft tissue damage to the neck of a patient by giving a 12 percent overdose of iridium.
- Overloading an applicator used in treating cancer of the uterus, resulting in radiation three times the prescribed dose. No evidence of abnormalities of the vagina were discovered.
- Overexposing a patient with cobalt in treatment of a brain tumor, resulting in an "unduly brisk scalp reaction" by the patient. Treatments were stopped until the scalp returned to normal.

Based on these reports, the NRC estimated that about 13 percent of the licensed hospitals would report at least one misuse of medicines annually.

Since the problems covered in this report, many hospitals have proposed improvements in handling of drugs and correctly identifying patients, the NRC said.

The report, prepared by the NRC Office for Analysis and Evaluation of Operational Data, also criticized hospitals for failing to fully detail problems with radioactive medicines. It said about one-third of the reports contained insufficient information.