TTT 1.52 HQ report copy

University of Wisconsin-Madison

SAFETY DEPARTMENT
317 N. Randall Avenue
MADISON, WISCONSIN 53715
608 262-8769 - 262-0667

SAFETY IS OUR CONCERN...

April 6, 1981

30-3465

FIRE

Dr. William Adam
U.S. Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, IL 60137

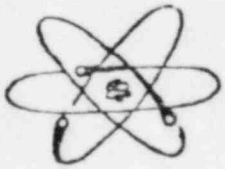
RE: License No. 48-09843-18
Report of Diagnostic Misadministration

WATER

Dear Dr. Adam:

The information below concerning a misadministration of a radioactive drug used in a diagnostic procedure is submitted in accordance with 10CFR35.43.

1. Licensee name: University of Wisconsin-Madison.
2. Referring physician: [redacted]
3. Description of event: A patient scheduled to receive Tc-99m methylene diphosphonate for a bone scan was injected with approximately 5mCi of Tc-99m sulfer colloid. The error was immediately noted and a liver scan was conducted. The patient was injected with approximately 20mCi of Tc-99m methylene diphosphonate on the following day and a bone scan was performed.



RADIATION

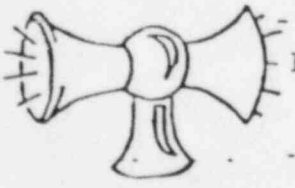
4. Effect on the patient: No adverse effects resulted from this misadministration. The dose from the injection of the Tc-99m sulfer colloid cannot be considered to be without benefit since useful diagnostic information was obtained.
5. Action taken to prevent recurrence: Technicians administering radiopharmaceuticals have been instructed to double check to be certain of the identity and quantity of material before it is used.

INDUSTRIAL

Sincerely,

Elsa Nimmo

Elsa Nimmo
Health Physicist



DISASTER CONTROL

EN/cd

(4)

APR 8 1981

University of Wisconsin Hospital and Clinics
CENTER FOR HEALTH SCIENCES
University of Wisconsin—Madison
600 Highland Avenue • Madison, Wisconsin 53792
2/23/81

Re: [redacted]
UW Hospital [redacted]

RECEIVED
FEB 25 1981
DEPARTMENT OF SAFETY

Paul Carbone, M.D.
Department of Human Oncology
University Hospital
Madison, Wisconsin

Dear Dr. Carbone:

On 2/17/81, the above patient was scheduled to receive a bone scan using Tc-99m methylene diphosphonate. She was inadvertently given an injection of Tc-99m Sulfur Colloid, the material used for routine liver and spleen scans. This constitutes a misadministration, and under the rules and regulations of our Nuclear Regulatory Commission (NRC) license, we are required to notify you of this in writing. The patient was advised of this misadministration.

I believe that a liver scan would have been ordered for this patient in the course of her work-up, however, this does not absolve the Section of Nuclear Medicine from notifying you and including this misadmistration in the quarterly report to the NRC.

If you have any questions or comments, please do not hesitate to call me.

Sincerely,

Lionel M. Lieberman, M.D.
Professor of Radiology and Medicine
Section of Nuclear Medicine

LML:pmw
cc: [redacted] M.D.
Elsa Nimmo