

144 HQ report Copy

THEDA CLARK REGIONAL MEDICAL CENTER

130 SECOND STREET • NEENAH, WISCONSIN 54956 • PHONE (414) 729-3190

April 9, 1981

30-3463

Region III, USNRC
Office of Inspection and Enforcement
799 Roosevelt Road
Glen Ellyn, Illinois 60317

Subject: Misadministration of a Diagnostic Radiopharmaceutical

Dear Sir:

This is to inform you of a misadministration of a partial diagnostic dose of Technetium Tc 99m Sulfur colloid which occurred at Theda Clark Regional Medical Center, License #48-09494-01 on 30 March, 1981 to a patient of Dr. []

The description of the circumstances and particulars of the misadministration are described in an enclosed letter to me from Thomas M. Seurer, Chief Technologist. The estimated dose of 750 microcuries of Technetium Tc 99m sulfur colloid were administered unnecessarily without detectable adverse effects. An estimated total body dose of 10-15 millirads was given to the patient unnecessarily. The Medical Isotope Committee of Theda Clark Regional Medical Center met today, 9 April, 1981 and reviewed the circumstances of the misadministration and reviewed the inservice conducted on 2 April, 1981 for all Nuclear Medicine technologists regarding awareness of the problems leading to misadministration of radiopharmaceuticals.

Sincerely,

Timothy T. Flaherty, M. D.
Chairman, Medical Isotope Committee

TTF/su

Enc.

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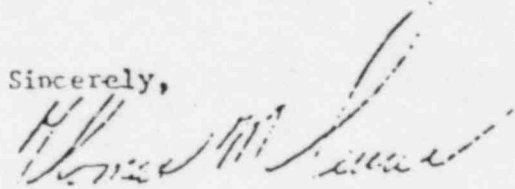
TO: T. T. FLAHERTY, M.D.
Medical Director Section of Nuclear Medicine

SUBJECT: Mis-administration of a diagnostic radiopharmaceutical

Dr. Flaherty:

This is to inform you of a misadministration of a diagnostic dose of 99M Technetium sulfur colloid which occurred at Theda Clark Regional Medical Center on March 30, 1981 to a patient of [] M.D. A stamped requisition including patients' room number for a bone scan was received by the Nuclear Medicine section. The technologist responsible for injecting the dose drew up a dose to be injected for a bone scan. Two bone scans were to be injected at the same time and in-between drawing up the first dose, inadvertently picked up a vial of 99M Technetium sulfur colloid and drew the second dose from this vial. The patient was then injected with 99M Tc sulfur colloid and 3 hours later, when the patient arrived in the department, no activity was seen over the cranial vault. Moving the patient down it was discovered that the concentration appeared to be in the liver and spleen. It was then decided that the next day we would again inject 99 Technetium Medronate sodium to see if this material would indeed go to the bone, or if we had encountered a bad tag or some clinical reasons for the material to go to the liver. On March 31, 1981 the patient was injected with Technetium 99M Medronate sodium, and 3 hours later, brought to the department at which time the material was in the bone. At that time, Dr. [] was contacted and informed that we had a misadministration of a radiopharmaceutical. The patient had no detectable adverse effects from the misadministrated dose, however, he did receive 750 microcuries of radiation unnecessarily. The responsible technologist was then consulted on the proper procedure for checking doses and a staff meeting will take place on this date to reaffirm procedures and to check our procedure to see if they can be improved so an occurrence of this type will not happen again.

Sincerely,



Thomas M. Seurer, Chief Technologist
Section of Nuclear Medicine