

April 4, 1994

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-II-94-017

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region II staff on this date.

Facility

Orlando Cancer Center Radiation Oncology  
Orlando Cancer Center  
50 West Sturtevant Street  
Orlando, Florida 32802  
License No: FL-2137-1

Licensee Emergency Classification

Notification of Unusual Event  
Alert  
Site Area Emergency  
General Emergency  
X Not Applicable

Subject: BRACHYTHERAPY MISADMINISTRATION

Florida, an Agreement State notified Region II of a medical misadministration to one patient while using a Nucletron, Microselectron model, High Dose Rate (HDR) device containing 9.6 curies of iridium-192.

Initial information indicates that the licensee performed a source exchange on March 30, 1994. The old source containing 4.35 curies was replaced with a 9.6 curies source. The Physicist intended to recalibrate the device over the weekend, since no treatments had been scheduled for the rest of the week. On Friday, April 1, a treatment was given using the "old" activity of 4.35 curies, resulting in an overexposure.

The treatment reportedly called for 1200 cGy (rads) to be delivered in two fractionated doses. Instead, approximately 1200 rads were given in one dose.

Florida has confirmed that no additional patients will be treated until the State is assured that adequate protective actions have been taken by the licensee. A State inspector is onsite, and a full investigation will be conducted by the State.

This information is all that is known as of 1:30 p.m., Monday, April 4, 1994.

News media coverage is not expected.

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