Li #20-1412-05
DOCKET 30-09946
3-60

Baystate Medical Center

Springfield Hospital Wesson Memorial Hospital Wesson Women's Hospital

Suresh M. Brahmavar, Ph.d., Director
Dept. of Medical Physics and Radiation Safety
April 5, 1983

U.S. Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, PA 19406

Subject: Misadministration of Isotope Reports: First Quarter, 1983
NRC License #20-1412-05

Gentlemen:

As per NRC regulations 10 CFR, Part 35, dated 11/10/80, the enclosed reports (2) are sent to you. The supporting documents related to these incidents are maintained in Radiation Safety Office at Baystate Medical Center.

Thank you.

Sincerely yours,

[signature] 4/5/83

Suresh M. Brahmavar, Ph.d.
Director, Medical Physics and Radiation Safety
Radiation Safety Officer

cc: Robert A. Grugan, M.D.
Lee Hilling
James Polga, M.D.

F/110

...nut Street · Springfield, Massachusetts 01107 · 413 · 787 · 3200

IX30

Baystate Medical Center
Springfield Hospital Wesson Memorial Hospital Wesson Womens Hospital

MISADMINISTRATION OF RADIOISOTOPE REPORT

1. Licensee Name: Baystate Medical Center : SHU
   759 Chestnut Street
   Springfield, MA 01107

2. Referring Physician: Physician A, Physician B

3. Description of Event: On March 14, 1983, a patient came to Nuclear Medicine Laboratory for a lung scan. Technolcgist A made up the lung scan solution and drew up a dose. Technologist B injected the patient. It was immediately discovered that the solution made up was Tc^{99m} pyrophosphate instead of Tc^{99m} aggregated albumin. Since the patient was injected with 4.0 mCi of Tc^{99m} pyrophosphate the lung scan images could not be taken. The patient was informed of the error and consented to return to Nuclear Medicine later that day for the lung scan. The patient's Physician A and the Nuclear Medicine Physician B were informed.

4. Effect on Patient: No visible effects were seen. The whole body dose was estimated to be 40 mR.

5. Action Taken to Prevent Recurrence: To double check vial labels on all solutions.

6. Reports and Records: The report will be discussed at the next Radiation Safety Committee meeting to be held in June, 1983. A copy of this report will be sent to NRC at the end of the first quarter of 1983. A copy of this report with all the names of individuals involved in this incident will be maintained in Radiation Safety Office.

Report Prepared By: Suresh M. Brahmavar, Ph.D.
Director, Medical Physics & Radiation Safety
Radiation Safety Officer
NRC License #20-01412-05
Date: March 30, 1983

Required by NRC regulations: 10 CFR Part 35 dated 11/10/80.

Suresh M. Brahmavar, Ph.D.
Director,
Medical Phusics & Radiation Safety

Said M. Zu'bi, M.D.
Director,
Medical Imaging Service

James Polga, M.D.
Chairman, Radiation Safety
Committee

cc: Robert A. Grugan, M.D.
Lee Hilling
M. Riddle
Alexander Szafran

Report Sent: U.S. Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, PA 19406

4/1683

SMB/lmd

Baystate Medical Center
Springfield Hospital Wesson Memorial Hospital Wesson Women's Hospital

MISADMINISTRATION OF RADIOISOTOPE REPORT

1. Licensee Name: Baystate Medical Center: SHU
   759 Chestnut Street
   Springfield, Mass. 01107

2. Referring Physician: Physician A, Physician B

3. Description of Event: On January 18, 1983 an outpatient came to the nuclear medicine laboratory for a renal scan. Technologist A drew up the patients' scan dose (7.5 mCi) and gave it to Technologist B. Technologist B checked the label on the dose and injected the patient. The images taken after injection revealed that the patient was injected with Tc99m disofenin instead of Tc99m gluceptate sodium. Technologist C discovered the error immediately. A subsequent attempt was made to obtain the renal scan but the scan quality was inferior. The patient was informed of the error and consented to return on January 21, 1983 for the renal scan. The patients' Physician A and the nuclear medicine Physician B were informed.

4. Effect on Patient: The patient was examined by nuclear medicine Physician B and no visible effects were seen. The whole body dose was estimated to be 30 to 50 mR.

5. Action Taken to Prevent Recurrence: Greater separation between vials containing Tc99m labeled radiopharmaceuticals. Improved labeling of vial containers and double check before injection of patients.

6. Reports and Records: The report will be discussed at the next Radiation Safety Committee meeting to be held in June, 1983. A copy of this report will be sent to NRC at the end of the first quarter of 1983. A copy of this report with all the names of individuals involved in this incident will be maintained in Radiation Safety Office.

Report Prepared By: Suresh M. Brahmavar, Ph.D.
Director, Medical Physics & Radiation Safety
Radiation Safety Officer
NRC License #20-01412-05
Date: January 31, 1983

Required by NRC regulations: 10 CFR Part 35 dated 11/10/80.

(cont'd on page 2)

Reviewed By:

Suresh M. Brahmavar, Ph.D.
Director,
Medical Physics & Radiation Safety

Said M. Zu'bi, M.D.
Director,
Medical Imaging Service

James Polga, M.D
Chairman,
Radiation Safety Committee

cc: Robert A. Grugan, M.D.
Lee Hilling
M. Riddle

Report Sent:

4/6/83

U.S. Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, PA 19406

SMB/lmd