Jersey Shore Medical Center

DEPARTMENT OF DIAGNOSTIC IMAGING

1945 Route 33, Neptune, NJ 07753 (908) 776-4398

June 30, 1993

Nuclear Regulatory Commission
Medical Academic and Commercial
Use Safety Branch
MS OWFN6H3
Washington, DC 20555

Re: Response to Patient Notification Inquiry

Dear Sir or Madam:

I am responding to your letter of June 3, 1993, directed to Mr. Ferrell, Administrative Director of Diagnostic Imaging at Jersey Shore Medical Center. This will reference License No. 29-02234-03 and Docket No. 030-29116.

For your information, I am enclosing a copy of the Radiation Therapy progress notes on patient EH. You will note that on November 3, 1992 the dose error was discovered and the attending physician, Dr. Thompson, was notified by the radiation oncologist, Dr. Ho, that there was a 60 Cobalt teletherapy overdose for 5 treatments between October, 28 1992 and November 3, 1992. This matter was addressed subsequently by Region 1 of the Nuclear Regulatory Commission at King of Prussia, Pennsylvania, attended by Mr. Ferrell, myself, and other technical and administrative representatives from Jersey Shore Medical Center.

You will see from progress notes that although Dr. Thompson, who was notified, did not feel that the patient had to be informed of the overdose, Dr. Ho, however, did inform the patient anyway, as is documented on the enclosed copy. The date of this also was November 3, 1992.

No written report was provided to the patient. The patient is alive and doing well. He is being followed by Drs. Ho, Thompson and his family physician.

At the time of this letter, both Drs. Ho and Thompson are away on professional business and are not available for further questioning. I anticipate both will have returned by the middle or end of July.

Sincerely,

Thomas Witomski, M.D.

Thomas Witomski, M.D.
Radiation Safety Officer
Jersey Shore Medical Center

TW:MC
cc: Dr. Ho.
Dr. Thompson
Lynn DiPoola
Jim Ferrell

210032

9410240279 930630
PDR ADOCK 03029116
C PDR

IE:07

RETURN ORIGINAL TO
REGION 1

Patient Name Hancox, Ernest Date 10-19-92 Chart No 160681

Progress Notes

11-3-92 wt 171 lbs 106/74 Appetite fair TD900cGy
Suggested Ensure cont XRT

11/3/92 Error in dose discovered to be 1500cGy instead of 900cGy
1pm Dr Thompson notified who feels we do not have to notify pt but still carry dose to full microscopic disease dose even though pt has metastatic disease with chart NRC will be notified Dose revised. Pt notified anyway

11/10/92 Wt 172 lbs BP 140/72 [illegible] Nosebleed 3-4 times (small amt) Sent to lab for Chem Batt, CBC, PT PTT — [illegible]

11-17-92 wt 170 lbs 128/80 diff swallowing - using Mylanta + Sucrafate c̄ relief, no SOB s̄ exertion
Tables Persantine & stable otherwise cont XRT

11-23-92 wt 170 lbs TD40Gy No dysphagia
Stable cont XRT

12/1/92 TD4200cGy 8x c̄ change stable cont XRT.
RTC 1/21/93 Hold CXR per Dr Thompson

12/7/92 Final (Exam) yesterday Thompson/ Quezada lf

12/28/92 c/o had pains x1 wk now localized to RT side "kidney area" waistline. IVP + US gallbladder OK
Takes pain meds q 4h suggest F/u 10A tomorrow
An [illegible] adrenal mets

12/28/92 Thompson/ Quezada

To James Dyer
Nuclear Regulatory Commission
Fax (215)-337-5269

July 19, 1993

From: Lynn DiPaolo, M.S
(908) 776-4420
License 29-02234-03
Docket 030-29116
Jersey Shore Medical Center

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