September 1, 1998

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-III-98-041

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 Region III staff (Lisle, Illinois) on this date.

Facility	Licensee Emergency Classification
Cook County Hospital	Notification of Unusual Event
Cook County Hospital	Alert
Chicago, Illinois	Site Area Emergency
License No: IL-01768-01	General Emergency
	X Not Applicable

Subject: BRACHYTHERAPY MISADMINISTRATION (UNDERDOSE)

On September 1, 1998, the Illinois Department of Nuclear Safety (IDNS) reported to NRC that a medical misadministration was identified at Cook County Hospital, Chicago, Illinois, on August 31, 1998.

The misadministration occurred during a cervical cesium-137 brachytherapy cancer treatment. The treatment was interrupted by the patient approximately 10 hours into the 31- hour treatment. The patient removed the applicator, dropped it to the floor and left the room. The prescribed dose was 2000 rads (20 gray) and the dose delivered to the patient was 692 rads (6.9 gray). No other site received an unintended dose. The Radiation Safety Officer and Oncologist promptly recovered and secured the sources.

The attending physician decided not to continue the brachytherapy treatment and may use external beam therapy to supplement the dose already received. The patient was notified of the misadministration.

The licensee will send a 15-day report to IDNS.

The NRC Office of State Programs (OSP) and Nuclear Material Safety and Safeguards (NMSS) were notified of the incident. OSP notified the NRC Operations Center of the incident at approximately 3:00 p.m. (CDT) on September 1, 1998. This information is current as of 4:00 p.m. (CDT) on September 1, 1998.

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