

José M. Colón Vaquer, M.D.

OFTALMOLOGO  
ESPECIALISTA ENFERMEDADES  
Y CIRUGIA DE LOS OJOS

→ PDR  
Doct's Ctr

March 6, 1998

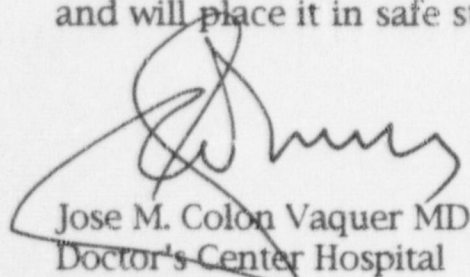
Mr. Charles Hosey  
Division of Nuclear Materials Safety  
US Nuclear Regulatory Commisision  
Region II  
Atlanta Federal Center  
61 Forsyth St.SW Suite 23T85  
Atlanta GA 30303-3415

RE: Jose M. Colon Vaquer, MD - Licensse  
License # 52-25113-01

Dear Mr. Hosey:

This is in reference to the preliminary findings from the NRC  
inspection conducted at my office on March 5, 1998.

In accordance to the directives given by Mr. Jose Diaz, effective  
inmediately, I will suspend the use of my SR-90 Beta eye applicator  
and will place it in safe storage until it is determined otherwise.

  
Jose M. Colon Vaquer MD  
Doctor's Center Hospital  
Suite 402  
Manati, PR 00674

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PDR

*José M. Colón Vaquer, M.D.*

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March 6 1998

Mr. Charles Hosey  
Division of Nuclear Materials Safety  
US Nuclear Regulatory Commisision  
101 Marietta St. NW Suite 2900  
Atlanta GA 30323-0199

RE: Jose M. Colon Vaquer, MD - License  
License # 52-25113-01

#### MISADMINISTRATION REPORT

I hereby notify of two misadministrations of Beta Radiation therapy events .

The first misadministration event occurred on august 23,1994 where the intended dose was to have been 1000 Rads and the actual dose was 1500 Rads.

The second misadministration event occurred on september 27,1994 where intended dose was to have been 1500 Rads and the actual applied dose was 1000 Rads.

Both of these events occurred because of not following procedures as per the QMP.

There should be no harmful effects to both individuals as in the first case such underdosage will not significantly augment the probabilities of recurrence of the pterigium, and in the second case the dosage recieved is still below the 2000 Rads per treatment commonly used .

An strict following of the QMP must at all times be observed in order for these events not to occur again. As a direct action to prevent this from happening again, absolutely no further treatments will be performed and the Beta source will be placed in safe storage. At this time arrangements to transfer the souce are being made.

Both patients have been notified within 24 hrs. of discovery, by phone and/or certified mail, as to the ocurrence of the misadministration, and its effects upon them if any . Both patients have been scheduled for appointments for evaluation within the next week.



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