DEPARTMENT OF THE ARMY
HEADQUARTERS, TRIPLER ARMY MEDICAL CENTER
TRIPLER AMC, HAWAII 96859-5000

REPLY TO
ATTENTION OF:

Radiation Protection
Office

SUBJECT: Report of Diagnostic Misadministration,
17 June 1986

U. S. Nuclear Regulatory Commission Region V
Inspection and Enforcement Branch
ATTN: Mr. Bob Thomas
1450 Marie Lane, Suite 210
Walnut Creek, California 94596

Dear Mr. Thomas:

References.

a. United States (US) Nuclear Regulatory Commission (NRC) Byproduct Material License (BML) 53-00458-04 (Human Use).

b. Letter, Radiation Protection Office, Tripler Army Medical Center, Hawaii dated 25 June 1986, subject: Report of Diagnostic Misadministration, 17 June 1986.

c. Telephonic communication between Mr. Bob Thomas, US NRC, Region V, and Captain Douglas G. Ashby, Radiation Protection Officer, Tripler Army Medical Center, Hawaii, 2 July 1986.

Request for additional information, reference c, above, concerning diagnostic misadministration, reference b, is provided as an enclosure.

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For further information on this incident please contact Captain Douglas G. Ashby at (808) 433-6925/6471.

Sincerely,

Paul D. Robertus
Major, U.S. Army
Chief, Administrative Services

Enclosure

Copies Furnished:

Commander
US Army Health Services Command
ATTN: HSCL-P
Fort Sam Houston, Texas 78234

Department of the Army
Office of the Surgeon General
ATTN: DASG-PSP-E
5111 Leesburg Pike
Falls Church, Virginia 22041-3258

DEPARTMENT OF THE ARMY
HEADQUARTERS, TRIPLER ARMY MEDICAL CENTER
TRIPLER AMC, HAWAII 96859-5000

REPLY TO
ATTENTION OF

HSHK-DR-N

3 July 1986

SUBJECT: Diagnostic Misadministration of Radioactive I-131 by Mouth to [redacted] on 16 June 1986

Tripler Army Medical Center
Radiation Protection Office
Tripler AMC, HI 96859-5000

1. The diagnostic misadministration of radioactive iodine P.O. I-131 to [redacted] in the Nuclear Medicine Service at Tripler Army Medical Center was reported to appropriate authorities in the hospital as well as Nuclear Regulatory Commission through Radiation Protection Officer by Mr. Merritt Clark.

2. [redacted] was scheduled to have a thyroid scan with 50 uCi of I-131 P.O.. However, the individual who dispensed the radioactive iodine fail to read the prescription and dispensed 3.0 mCi of I-131, which is our normal prescribed dose for whole body iodine survey.

3. At present, our practice in radiopharmacy consist of one individual drawing the requested amount of the radioactive material and another person checking it in terms of the amount of the material present as well as the type of the material before dispensing. If this procedure would have followed in the Radiopharmacy then the question of misadministration should not have occurred at all. However, in this particular case, there was breakdown in normal procedure.

4. Considering the gravity of situation in terms of misadministration, we have modified our dispensing procedure for radioactive iodine as follows:

a. The current procedures will remain unchanged for dispensing of the radioactive iodine for uptake studies as they are dispensed in a capsule which are pre-calibrated and it is less likely that any mistakes will be done in dispensing.

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HSHK-DR-N
SUBJ: Diagnostic Misadministration of Radioactive I-131 by Mouth to [redacted] on 16 Jun 86

b. In all other cases, the final dispensing and checking of the dose will be done by a staff physician or radiology resident assigned to Nuclear Medicine Service.

c. The identification of the patient as well as final amount dispensed will be co-signed by the physician involved in that particular procedure.

5. Other appropriate administrative actions are pending. However, we believe that above described changes will certainly avoid any misadministration in the future.

6. The above described changes are in effect by the order of the Chief of the Service, Dr. John S. Kolina, and will be instituted in writing when administration clearance is finalized.

for Merrill Clark
R. B. SHAH
LTC MC
Acting C, Nuc Med Svc

JUL 9 1986

MEMORANDUM FOR: C. J. Heltemes, Jr., Director, Office of Analysis and Evaluation of Operational Data

FROM: James L. Montgomery, Chief, Nuclear Materials Safety and Safeguards Branch

SUBJECT: ABNORMAL OCCURRENCE REPORT

A diagnostic misadministration was reported to Region V from the Tripler Army Medical Center, Tripler AMC, Hawaii. In our opinion, the event meets the AO reporting threshold for an Event Type (4) for a Diagnostic Exposure as listed in Table 1 - Specific Guidelines

Date and Place - On June 17, 1986, at the Tripler Army Medical Center, Tripler AMC, Hawaii (NRC License No. 53-00458-04) a patient received a dose of 3.09 mci of I-131 instead of a prescribed dose of 50 uci for a thyroid imaging procedure.

Nature and Probable Consequences - A 54 year old female patient was given a 3.09 mci dose of I-131 by mistake. The patient was scheduled for a thyroid imaging procedure which utilizes only 50 uci of I-131. The radiation exposure received by the patient due to the 3.09 mci I-131 dose is estimated to be:

(a) 2472 Rad to the thyroid
(b) 0.43 Rad to the ovaries
(c) 1.45 Rad to the whole body

Contact with the licensee was made on July 9, 1986 regarding any possible clinical symptoms or adverse health effects due to the 3.09 mci I-131 dose. The licensee stated that the patient had been hospitalized for observation. On July 6, 1986 the patient was discharged due to the lack of any clinical symptoms. The patient has been scheduled for 90 days interval checkups at her duty station on Guam. An annual medical workup has also been scheduled.

Cause or Causes - This misadministration was the result of an isolated incident of misreading the consultation sheet.

18.

OFFICE	RV	RV					
SURNAME	RThomas	Montgomery:ms					
DATE	7/9/86	7/9/86					F/17

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Action Taken to Prevent Recurrence -

Licensee - Effective immediately, the dispensing procedure for radioactive iodine is as follows:

(a) In all cases, the final dispensing and checking of the dose will be done by a staff physician or radiology resident assigned to Nuclear Medicine Service.

(b) The identification of the patient as well as the final amount dispensed will be co-signed by the physician involved in that particular procedure.

(c) The quality assurance manual for Nuclear Medicine Service is being updated to stipulate the new review procedures.

NRC - The circumstances of the misadministration were discussed in detail with the licensee on July 3, 1986 by a member of the regional management staff. The licensee's corrective actions appear to be acceptable. The NRC will not issue any further requirements in this matter at this time. The matter will be reviewed again during the next inspection.

This incident is closed for purposes of this report.

/S/

James L. Montgomery, Chief
Nuclear Materials Safety and
Safeguards Branch