March 8, 2002

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-02-014

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 the Region IV staff on this date.

Facility
St. Bernard's Regional Medical Center
225 East Jackson Ave.
Jonesboro, AR 72401
License No.: ARK-365-BP-07-97
State of Arkansas Licensee

Licensee Emergency Classification
___ Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
__X__ Not Applicable

SUBJECT: MEDICAL MISADMINISTRATION

DESCRIPTION:

On March 7, 2002, the NRC was notified by the Arkansas Department of Health (ADH) of a therapeutic medical misadministration involving a the Novoste Beta-Cath System, a catheter-based brachytherapy system. The event occurred at St. Bernard's Regional Medical Center in Jonesboro, Arkansas.

On February 26, 2002, the licensee attempted to perform a vascular brachytherapy procedure involving a beta radiation source train containing a nominal activity of 2.22 gigabequerel (60 millicurie) of strontium-90. Following the initial source train send, the proximal gold marker could not be discerned under flouroscopy due to wire suture in the patient's sternum. Twenty-four seconds elapsed between the arrival of the distal marker at the treatment site to source return to the delivery device. Two additional source sends were attempted with immediate return of the sources due to the inability to discern the proximal marker. Because the proximal marker could not be visualized, the licensee could not establish the positioning of the sources between the distal marker at the treatment site and the delivery device; therefore, the licensee could not verify that an unintended area had not been treated with the sources. The ADH arranged for a medical expert to review the cine images on March 7, 2002. The ADH has requested that the licensee provide dose calculations based upon the 24 second source dwell time. The licensee has 15 days to provide a written report.

Region IV received notification of this occurrence by facsimile from ADH at 1:50 p.m. (CT) on March 7, 2002. On March 4, 2002, RIV received a preliminary notification of the event pending the need for additional information.

Region IV has informed NMSS, STP and OEDO.

This information has been discussed with the State and is current as of 4:00 p.m. (CT), March 7, 2002.

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