

August 1, 2003

This Event is not for public disclosure per Agreement State request until 8/5/2003

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-III-03-034

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 III staff on this date.

<u>Facility</u>	<u>Licensee Emergency Classification</u>
Rush Copley Medical Center	<input type="checkbox"/> Notification of Unusual Event
Aurora, Illinois	<input type="checkbox"/> Alert
License: IL-01207-01	<input type="checkbox"/> Site Area Emergency
(Agreement State licensee)	<input type="checkbox"/> General Emergency
	<input checked="" type="checkbox"/> Not Applicable

SUBJECT: MEDICAL EVENT (WRONG ISOTOPE)

DESCRIPTION:

On July 31, 2003, the Illinois Department of Nuclear Safety (IDNS) notified the NRC Operations Center of a medical event which occurred on July 28, 2003, at Rush Copley Medical Center in Aurora, Illinois. IDNS was notified of the medical event by a licensee Nuclear Medicine technologist on July 29, 2003.

A patient received a 4 millicurie unit dose of I-131 [Iodine-131] instead of the prescribed 4 millicurie unit dose of Tl-201 [Thallium-201] for a heart test on July 28, 2003. According to the technologist, both the exterior lead container and the syringe were labeled as Tl-201 by Medi-physics/Amersham Health nuclear pharmacy in Wood Dale, Illinois. According to a nuclear pharmacy representative, the syringe and the lead container were mislabeled. The error resulted in an unintended dose to the thyroid and other organs. The licensee and IDNS will continue its analysis of this event. Both organizations are performing evaluations of the dose to the patient's thyroid and other organs. Medi-Physics/Amersham Health is also investigating the circumstances surrounding the mislabeling of the unit dose at its Wood Dale, Illinois, nuclear pharmacy.

The licensee's radiation oncologist does not believe there will be any appreciable health effects to the patient. The licensee has offered to provide routine blood testing of the patient throughout the year for thyroid hormone levels as part of its follow-up evaluation.

The NRC's Office of State and Tribal Programs and Office of Nuclear Materials Safety and Safeguards have been notified. The NRC's Region III (Chicago) Office is monitoring the State's investigation. This information is current as of 1:00 p.m. CDT on August 1, 2003.

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