

August 20, 2003

This Event is not for public disclosure per Agreement State request until August 22, 2003

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-III-03-035

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 North Shore Medical Center	<input type="checkbox"/> Notification of Unusual Event
Skokie, Illinois	<input type="checkbox"/> Alert
License No: IL-01578-01	<input type="checkbox"/> Site Area Emergency
(Agreement State licensee)	<input type="checkbox"/> General Emergency
	<input checked="" type="checkbox"/> Not Applicable

SUBJECT: MEDICAL EVENT (WRONG TREATMENT TIME)

DESCRIPTION:

On August 19, 2003, the Illinois Emergency Management Agency (IEMA), Division of Nuclear Safety, notified the NRC Operations Center of a medical event which occurred on August 18, 2003, at Rush North Shore Medical Center (licensee) in Skokie, Illinois.

A patient was undergoing an intravascular brachytherapy (IVB) procedure using a Novoste strontium-90 (Sr-90) device. The prescribed dose was 23 gray (2300 rad). The treatment plan called for a treatment time of 4.09 minutes. Due to difficulties in retracting the source, the actual treatment time was 5.09 minutes, one minute longer than planned. Preliminary estimates indicate that the delivered dose exceeded the prescribed dose by approximately 25 percent.

The manufacturer of the device, Novoste, has been notified. A representative of Novoste has gone to the medical center and is assisting the licensee in its investigation of the event. The device will be shipped to Novoste for analysis. The licensee is completing dose calculations and will submit a report to the State of Illinois. The State is continuing its investigation.

The licensee does not believe there will be any adverse health effects to the patient.

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 10:30 a.m. CDT on August 20, 2003.

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