Bristol Hospital

P.O. Box 977
Bristol, CT 06011-0977
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http://www.bristolhospital.org

MEDICAL EVENT 15 DAY REPORT

(i) NRC Licensee:
Bernard Percarpio, MD
Bristol Hospital, Bristol CT

(ii) Prescribing Physician
Bernard Percarpio, MD

(iii) Event:
A 59 year old male with localized prostate cancer had an ultrasound directed transperineal implant with 60 I-125 seeds on 1/12/2010. The total activity implanted was 20.4 mCi. Final dosimetry was based on a CT scan performed on 2/16/2010. This revealed a D90 of 8400cGy which was lower than the prescribed dose of 14500cGy. The patient and referring physician were notified and the patient then received supplemental external beam irradiation of the prostate with 3000cGy delivered between 3/11/2010 and 4/08/2010. The patient is currently doing well with minimal treatment related symptoms.

(iv) The event occurred because the radioactive seeds were displaced in an inferior (caudal) direction by approximately 5-6 mm. This displacement may have occurred because of patient movement during the implantation procedure, inattention to implant needle placement in the "Z" axis during the procedure, diminished attention to "slow" needle withdrawal from the prostate or unusual swelling/bleeding in the prostate base region.

(v) The patient required additional external beam irradiation with minimal resulting side effects.

(vi) Since this event occurred, we have paid increased attention to meticulous implant needle placement in the "Z" axis. We have also made sure that needles withdrawal from the prostate is done in a slow and deliberate motion in order to allow more accurate seed placement. We have also increased our insistence on patient immobilization and appropriate anesthesia to decrease the chances of patient movement during the implant procedure.

(vii) Office notes on 3/01/2010 document that the patient was notified.

6/25/10

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(ii) Prescribing Physician
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(iii) Event:
A 68 year old man with localized prostate cancer had an ultrasound directed transperineal implant with 66 Cs-131 seeds on 1/12/2010. The total activity implanted was 186 mCi. Final dosimetry was based on a CT scan performed on 2/16/2010. This revealed a D90 of 6500cGy which was lower than the prescribed dose of 11000cGy. All seeds were accounted for in the final review. However, careful review of the isodose lines revealed adequate coverage of the involved areas of the prostate. The patient and referring physician were notified and the prescribing physician indicated that additional treatment was not necessary.

(iv) The event occurred because the radioactive seeds were displaced in an inferior (caudal) direction by approximately 5-6 mm. This displacement may have occurred because of patient movement during the implantation procedure, inattention to implant needle placement in the "Z" axis during the procedure, diminished attention to "slow" needle withdrawal from the prostate or unusual swelling/bleeding in the prostate base region.

(v) The patient has experienced no effects beyond the usual symptoms related to prostate brachytherapy. His most recent follow up PSA has decreased to 0.7 (May 2010).

(vi) Since this event occurred, we have paid increased attention to meticulous implant needle placement in the "Z" axis. We have also made sure that needles withdrawal from the prostate is done in a slow and deliberate motion in order to allow more accurate seed placement. We have also increased our insistence on patient immobilization and appropriate anesthesia to decrease the chances of patient movement during the implant procedure
We continue to use preplanning for all prostate brachytherapy patients with careful direct supervision of needle and seed placement. Six (6) patients have been treated with brachytherapy at Bristol Hospital since January 2010 and the final dosimetry has been acceptable for all.

(vii) The patient was notified of the event and the need for continued medical follow up.

6/25/10