

# OLYMPIA FIELDS OSTEOPATHIC MEDICAL CENTER

September 25, 1984

NRC Region III  
799 Roosevelt Rd.  
Glen Ellyn, Illinois

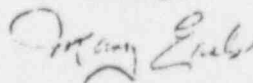
Chicago Osteopathic Hospital  
Medical Pathology, Physiology and  
Pharmacology Departments  
5200 S. Ellis Avenue  
Chicago, Illinois 60615  
~~License #12-04390-01~~

Dear Sir:

This is to notify you of a diagnostic misadministration which occurred at Olympia Fields Osteopathic Medical Center on 9-12-84 in the Nuclear Medicine Department. The attending physician was Dr. Kathleen Casper. A fourteen year old male was injected for a renal scan with 5 mCi of Tc-MDP by mistake; the patient did not experience any side effects resulting from this incident.

Unit doses are provided by Nuclear Pharmacy Inc. in Chicago. In this particular case the lead syringe holder was labeled Glucoheptenate but the syringe contained MDP instead, resulting in the misadministration. As a result of an apparent breakdown in the internal quality control policies and procedures by the staff of Nuclear Pharmacy Inc., two syringes were dispensed incorrectly in the wrong lead syringe holders. I have been assured by the pharmacy manager, Greg Doerr, that this issue has been appropriately addressed and that the necessary corrective action has been implemented at the pharmacy to prevent any future reoccurrence of this problem.

Sincerely,



Mary Earls  
Manager, Nuclear Medicine Dept.

ME/jo

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