PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-III-96-065

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 Region III staff (Lisle, Illinois) on this date.

Facility
ST. JOHN'S MEDICAL CENTER
St. John's Medical Center
Joplin,Missouri
License No: 24-01090-03

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

Subject: THERAPEUTIC MEDICAL MISADMINISTRATION

On October 22, 1996, a patient was undergoing endobronchial treatment with 1.46 gigabequerels (39.48 millicuries) of iridium-192 seeds. The catheter containing the seeds was inserted into the patient's endobronchial area to relieve a tumorous obstruction at 2:15 p.m. The prescribed treatment directed the catheter, containing 30 iridium-192 seeds in a ribbon, to remain in place for 24 hours for a total of 948 millicurie-hours.

In actuality, the treatment site is estimated to have received an underdose of approximately 424 millicurie-hours At approximately 1:00 a.m. on October 23, 1996, the patient apparently dislodged the catheter due to an attack of violent coughing. At 8:30 a.m., the treating physician visited the patient and found the iridium-192 seed ribbon exposed such that it was visible at the tip of the patient's nose. The physician immediately removed the seed ribbon and contacted the hospital's Radiation Safety Officer.

Preliminary calculations by the licensee indicate that the lens of the patient's eye received a dose of 111 centigray (111 rads) and the patient's nasal area received a dose ranging from 363 to 762 cGy (363 to 762 rads).

The licensee does not expect any adverse consequences to the patient from the misadministration. The licensee has notified the referring physician and the patient of the misadministration. The physician has not yet determined whether the treatment will be resumed.

NRC Region III (Chicago) will review the circumstances surrounding misadministration during a future inspection.

The State of Missouri and the NRC Office of Nuclear Material Safety and Safeguards have been notified. The information in this preliminary notification has been reviewed with licensee management.

The licensee notified the NRC Operations Center of this event at 11:25 a.m. (CDT) on October 23, 1996. This information is current as of 8:20 a.m. (CDT) on October 24, 1996.

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