



# Status of Medical Events FY 2010

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# Medical Events 2010

- **47 Medical events reported - FY 2009**
- **49 Medical events reported - FY 2010**

	<u>FY09</u>	<u>FY10</u>
35.200	1	1
35.300	5	4
35.400	17	25
35.600	14	12
35.1000	10	7

# Medical Events 2010

## Diagnostic Medical Event

35.200

1

### Communication errors

- Referring physician intended I-123
- Wrote I-123 prescription and gave to patient
- Physician's office faxed request for I-131
- Hospital gave I-131
- Hospital refused patient's written prescription
- Technologist noted patient had thyroid

# Medical Events 2010

<b>35.300 Medical events</b>	<b>4</b>
– Oral Sodium Iodide I-131	3
• Wrong Patient	
• Left capsules in vial (2 events - 5 capsules)	
– MIBG I-131	1
Preparation volume error lead to air in infusion line	

# Medical Events 2010

<b>35.400 Medical events</b>	<b>25</b>
– Gynecological	3
– Anus	1
– Prostate	21

## 35.400 Medical Events

- |  |        |   |
|--|--------|---|
| <b>Gynecological</b>   | Cs-137 | 3 |
| <ul style="list-style-type: none"><li>• Applicator came out after 20 minutes – may have received 76 rem to thigh</li><li>• Applicator dislodged after vigorous coughing after 20 hours (total prescribed 45 hours)</li><li>• Failure to place sources in applicator one fell out and fell on buttocks (1,050 rad) other was missing and found in trash</li></ul> |        |   |

- |  |       |   |
|--|-------|---|
| <b>Anus</b>  | I-125 | 1 |
| <ul style="list-style-type: none"><li>• 4 cm superior to intended location – 10 cm mark mistaken for 5 cm mark</li></ul> |       |   |

## 35.400 Medical Events

### **Prostate (40 Patients) 21**

- 4 licensees had multiple medical events - licensee not reviewing results against medical event criteria
  - DVA had 11 under one medical event report
  - Mercy St Vincent Medical Center and an associated facility had 9 reported individually
  - Marshfield Clinic had 9 in one report and 1 in another report
  - Jewish Hospital had 2 events in one report
  - Bristol Hospital had 2 events in one report

## 35.400 Medical Events

### Prostate (Continued)

- 20 under dose to the prostate, no reason given
- 3 Over dose to prostate, no reason given
- 2 Multiple seeds eliminated from bladder or urethra
- 1 Tumor volume increase due to edema
- 11 Suboptimal dose distribution, poor placement, poor visualization, incorrect identification of prostate
- 3 Over doses to other organs (e.g., urethra)

# Medical Events 2010

**35.600 Medical events**      12

- HDR    9
- Mammosite                                2
- Gammaknife                                 3

# 35.600 Medical Events

## HDR Only (11 patients)

7

- 1 Software failure
- 2 Human error
  - hit “auto radiograph” instead of “treatment” button
    - – entered treatment site incorrectly
- 3 Catheter issues-tight bend, catheter movement
- 1 No reason given – 5 patients 30-50% under dosing

# 35.600 Medical Events

**HDR Mammosite (3 patients)** 2

- 2 source positioning error not discovered until after 10 of 10 fractions for patient 1 and 8 of 10 fractions for patient 2 –
- 1 incorrect distance measurement – used damaged source positioning simulator tool

## 35.600 Medical Events

### Gammaknife

3

- removed right anterior pin from frame - left pin slipped 2 cm superiorly
- wrong coordinates put in 1<sup>st</sup> 5 of 10 fractions – used x coordinate value for both x and z
- head immobilization bracket not fully secured – patient pain

# Medical Events 2010

## 35.1000 Medical events 7

- Perfexion 2
- Microspheres 4
- Intravascular Brachytherapy 1

## 35.1000 Medical Events

### Perfexion

2

- Wrong site – intended left side gave to right side of brain error discovered at 1.4 minutes into 30 minutes
- Failed computer disk froze treatment screen gave fatal error and terminated treatment intended

# 35.1000 Medical Events

## 35.1000 TheraSpheres 2

- Wrong site intended left lobe of liver delivered to right lobe – right lobe was scheduled to get dose on later date prescribed for later date 12,500 rad got 7,600 rad
- Waste container assay indicated 25% of pretreatment activity – iodine contrast media put in catheter, thought this impeded or caused aggregation.

## 35.1000 Medical Events

### SirSpheres

2

- Leakage around stopper – manufacturer confirmed leakage, but thought physician put too much pressure to V-vial
- Thought procedure delivered entire dose with out complication, but about 4.4 mCi of intended 15.4 mCi left in tubing vial and other contaminated items

## 35.1000 Medical Events

### Intravascular Brachytherapy

- Wrong treatment time selected for treatment intended 1,840 rad gave 2300 rad – AU did not sign written directive before administration