NRC NEWS

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NRC PROPOSES $14,000 FINE AGAINST VETERANS AFFAIRS SAN DIEGO HEALTHCARE SYSTEM FOR MISADMINISTRATION OF IODINE-131

The Nuclear Regulatory Commission has proposed a civil penalty of $14,000 against the Department of Veterans Affairs (DVA) San Diego Healthcare System for two violations of NRC regulations after a thyroid cancer patient was administered iodine-131 through the wrong port of a feeding tube.

"We expect license holders that use nuclear material in medicine to make sure they understand and adhere to NRC regulations, and that they have proper procedures and training for their staff to ensure that medical procedures with nuclear materials are delivered to patients safely and as prescribed," said Mark Satorius, regional administrator for NRC Region III office in Lisle, Ill.

The incident, in September 2009, resulted in an underdose to the patient's thyroid and an unintended dose to the stomach. The hospital's investigation revealed that the iodine had been mistakenly injected into the wrong port of a feeding tube which allowed the iodine to remain in the area of the stomach essentially acting as a sealed radiation source within the patient.

The DVA was cited for its failure to develop, implement and maintain adequate procedures, and failure to instruct technicians on those procedures. This was a significant programmatic weakness.

NRC inspectors also determined that hospital staff did not report the incident in a timely manner according to NRC requirements.

Daily radiation surveys following the administration of the iodine indicated radiation levels higher than expected. The levels measured were indicative of an ongoing presence of the radioactive material within the patient, not of the reduction in radiation levels if the radioactive iodine was being eliminated from the body through normal bodily functions. Patient imaging taken two days after the administration revealed a "hot spot" in the patient's abdomen. At this time, hospital staff should have realized a reportable medical event had occurred and informed the NRC within 24 hours. However, hospital staff took no further action for two additional days, at which time the feeding tube was removed from the patient. A day after the tube was removed,

the hospital reported the incident to the NRC. The failure to promptly inform the NRC of a medical event impacted the NRC's ability to promptly assess the circumstances and respond to ensure that public health and safety was not at risk.

The DVA has 30 days to respond to the notice of violation. The hospital has already taken corrective action to improve its procedures and training for administering radioisotopes.

The documents associated with this issue are available through the NRC RIII Office of Public Affairs and at the NRC web site: http://www.nrc.gov/reading-rm/adams/web-based.html.

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