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Misadministration Spurs Statewide Inspection of California Nuclear Medicine Departments

A mistaken injection with a used syringe that provoked a nuclear medicine patient to sue a San Diego hospital last July has prompted California health officials to survey infection control practices in 14 nuclear medicine departments across the state. The patient, a 23-year-old woman, alleges that techologists injected her with a syringe used on an HIV-positive patient, causing her "severe mental and emotional stress." Whether the woman was infected with the virus has not been revealed.

The study conducted by the California Department of Health Services (CDHS) is expected to result in the revision of Licensing and Certification Unit regulations (Title 22). Under the revisions, Consolidated Accreditation and Licensing (CAL) surveyors would begin inspections of nuclear medicine infection control practices, medical records, quality control, and radiation safety procedures. "When we first got word of the incident, we decided to examine infection control in several hospitals," says Donald Bunn, a CDHS senior health physicist. "We hadn't done anything preventative in the past."

The misadministration that spawned the CDHS study occurred on September 25, 1990 at Mercy Hospital in San Diego, California when the plaintiff was scheduled to receive a radionuclide bone scan of her lumbar spine and pelvis to detect the possibility of a herniated spinal disk. It was the third HIV-related nuclear medicine misadministration reported to the Centers for Disease Control (CDC) in Atlanta, Georgia within a six month period.

An attorney for Mercy Hospital, Cary Miller, Esq, says that the misadministration occurred when one of the two technologists involved found a recapped syringe near the area where doses for new injections are made and assumed it was a dose prepared for his patient. According to an investigation conducted by the CDC, the syringe, previously used on a lung scan patient, was not disposed of in the hospital's hot lab. Rather, it was placed on top of a refrigerator, a space normally used for newly prepared syringes. The report notes that materials left in the syringe were partially obscured by a lead shield.

The CDC account reports that despite the woman's late arrival for her scan, the technologist did not cancel the procedure, although he did express concern that the radiopharmaceuticals were time-calibrated. The technologist told CDC investigators that he did not read the color-coded label on the syringe and that he inserted the needle into the woman's arm, covered it with a lead shield, drew back blood twice to make sure he was in a vessel, and made the injection. He then instructed the woman to return for her scan in three hours.

A report submitted by the CDHS Radiologic Health Branch to the Nuclear Regulatory Commission (NRC) says that the patient should have received 20 mCi of technetium-99m medronate (^{99m}Tc-MDP) for a bone scan and was instead injected with approximately 400 μCi of technetium-99m macro aggregated albumin (^{99m}Tc-MAA) in a syringe that had previously been injected into an HIV-positive lung scan patient.

A spokesperson for Mercy hospital, Michael Scahill, says that "There was no blood communication because the previous patient was not directly injected with the syringe." According to the CDC report, the HIV-positive patient was injected via a heparin lock on a peripheral intravenous line.

When the two technologists later reviewed their records, they realized that they had administered the wrong dose, reports Mr. Miller. However, he says, they were not aware that the syringe had been used on an HIV-positive patient. The woman's lawyer alleges that the technologists performed a lung scan on her without her knowledge or consent and without physician approval. After completion of the procedure, the patient's lawyer further alleges, the technologists "falsely. . . represented to the plaintiff that the first injection had missed or burst the vein into which it had been placed" and administered a second injection followed by a bone scan, also without orders from a physician. The technologists, whose names were withheld by CDHS and Mercy Hospital, could not be reached for comment.

The next morning, says the CDC report, the technologists learned that the syringe had been previously used on an HIV-positive patient. Approximately thirty-eight hours post-exposure, the woman's referring physician notified her of the misinjection and, according to the state health services report, gave her 250 mg of prophylactic AZT every four hours. Although the woman's HIV status has not been revealed, the lawsuit alleges that she suffered "severe mental and emotional stress, extreme nervousness, emotional shock, physical illness, and stress."

According to the CDHS report, "the main breakdowns in routine procedures were: (1) the used lung scan syringe was not disposed of properly, immediately after the injection was completed; (2) the technologist injecting the bone scan patient did not check [assay the syringe in] the dose calibrator immediately prior to injection, did not read the patient ID label on the syringe or the pig (both were labeled), and did not notice the color coded (yellow) MAA sticker on the syringe."

Mercy Hospital has "tightened up its system" since the incident occurred, says Mr. Scahill. The hospital's procedure for "Radio-pharmaceutical Injection (I.V.) of the Patient" was revised, with an effective date of September 1990. The new procedure, according to the CDHS report, requires that the technologist who injects the radiopharmaceutical also pre-

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pare the radiopharmaceutical for injection and take steps to identify the patient and the radiopharmaceutical to be injected.

Meanwhile, the CDHS has filed charges against the technologists directly involved in the misadministration, which may result in revocation of their California certificates to practice nuclear medicine.

Leigh Silverman

Supreme Court Will Hear Case Against Radioactive Waste Policy Amendments Act

The U.S. Supreme Court decided in January to consider the State of New York's challenge to the Low-Level Radioactive Waste Policy Amendments Act, the 1985 law that set strict deadlines for the establishment of radioactive waste disposal sites across the country. The justices are scheduled to hear arguments in the case this month.

Advocates of the Federal law warn that if New York prevails in its lawsuit and the Court declares provisions of the act unconstitutional, the development of new disposal facilities would almost certainly grind to a halt—even as the states operating the country's three existing low-level waste sites prepare to bar out-of-state access to their dumps or close down altogether in 1993.

New York claims that the radioactive waste act violates state sovereignty and constitutionally protected principles of federalism. New York has particularly objected to the "take title" provision of the law, which requires each state to take possesion of privately generated waste in 1996 if the state or its regional compact has not built a disposal facility by that time.

By agreeing to hear the case, the Supreme Court has given new life to what has so far been a losing struggle against the radioactive waste act. Following the decision of a lower court, the U.S. Second Circuit Court of Appeals flatly rejected New York's challenges last summer (see *Newsline,* November 1991, p. 34N).

In spite of the decisive rulings against New York, the appeal has gained undisputable national significance—at least 15 states have joined in the *amicus curiae* briefs filed by Connecticut, Michigan, and Ohio on behalf of New York State and the two New York counties that are bringing the suit against the Federal Government.

Intervening on the side of the Federal defendents are South Carolina, Nevada, and Washington—the three states operating facilities that accept the entirety of the nation's low-level radioactive waste. A host of electric utility companies and other "generators" of low-level radioactive waste, including radiopharmaceutical companies and The Society of Nuclear Medicine (SNM) and the American College of Nuclear Physicians (ACNP) sought earlier to collectively intervene as a third party in the suit but were denied by a lower court and instead filed a brief as *amicus curiae.* In February, SNM and ACNP joined the utilities in filing a second *amicus curiae* brief on behalf of the Federal defendants. ■

New Way to Order Society of Nuclear Medicine Books

The Society of Nuclear Medicine (SNM) has changed the way it fulfills book orders. All orders for books and pamphlets published by SNM should be placed directly with BookMasters, SNM's fulfillment center, rather than with the SNM central office. The changes were made in January 1992 following cutbacks at the SNM office in New York and should bring modest cost savings for the organization, according to David Teisler, director of publications. Although the transition may cause some initial inconveniences, Mr. Teisler says the changes are expected to speed the delivery of books by two or three days. (Address SNM book orders to: Book Order Department, BookMasters, Inc., 1444 State Rt. 42, RD 11, Mansfield, OH 44903, telephone 1-800-247-6553, or fax 1-419-281-6883.) ■

Nuclear Medicine Week Goes International

The Society of Nuclear Medicine and the Technologist Section will promote Nuclear Medicine Week internationally this year following a request by the European Association of Nuclear Medicine to participate in the annual event. Nuclear Medicine Week activities are intended to increase awareness of the contributions of nuclear medicine to health care.

A promotional poster will be printed in five languages. Cynthia Wharton, CNMT, chair of the Nuclear Medicine Week Committee, says that the poster is less technical this year to reach a broader audience. The four-color poster encourages viewers to "see a world of clinical information through nuclear medicine."

The National Council of the Technologist Section recently voted to change the celebration dates of Nuclear Medicine Week from its traditional time in late July or early August to early October. In 1992, the event will be celebrated during the week of October 4–10. This change is intended to avoid scheduling activities at a time when many people, especially in Europe, are on summer vacation. Mickey Williams, CNMT, president of the Technologist Section, notes that the later date enables schools to participate while they are in session.

Ms. Wharton urges members to start planning Nuclear Medicine Week activities now. Members who would like more information may call Virginia Pappas, SNM Associate Executive Director, at the SNM central office (212-889-0717). ■