OHIO DEPARTMENT OF HEALTH
BUREAU OF RADIATION PROTECTION
35 EAST CHESTNUT STREET
COLUMBUS, OH 43266-0118

August 29, 2005

TO: ALL OHIO MEDICAL RADIOACTIVE MATERIAL LICENSEES WHO USE DIAGNOSTIC AND THERAPEUTIC QUANTITIES OF RADIOPHARMACEUTICALS OR BRACHYTHERAPY IMPLANTS.

Previously in August 2004 an information notice was sent to all Ohio Medical licensees who use unsealed radioactive material. This information notice requested licensee's to provide documentation of the nuclear medicine procedure, preferably in the form of a card, to patients prior to release from their facility. It has come to the attention of the Bureau that law enforcement officials are continuing to acquire sensitive radiation detection equipment which will detect a patient who has undergone a nuclear medicine procedure. The Bureau in cooperation with the Ohio Hospital Association has determined that it is necessary to create a special amendment to all medical licensees who use unsealed radioactive material. This amendment will require all affected licensees to issue a patient release card as required below. The amendment to the license will begin shortly with license categories 02110, 02120, 02200 receiving priority followed by categories 02121, 02201 02220 and 02299. The license amendment will contain the following license condition:

Any patient released from facility control who has been administered diagnostic or therapeutic quantities of radiopharmaceuticals or brachytherapy implants shall be provided a patient release card. The patient release card shall contain:
(1) The patient's name.
(2) The radionuclide administered and its activity.
(3) The facility name which administered the radionuclide, and a phone number available 24 hours a day, 7 days per week for inquiries about the administration.
(4) The date of the administration of the radionuclide.
(5) The expiration date of the card.

An abstract of the previous information notice is provided.

Any questions regarding this notice should be directed to Ms. Marcia Howard, Program Administration, Nuclear Material Safety Section, or Mr. Mark Light Supervisor at 614-644-2727

Description of Circumstances:

In a recent event a patient who had received a thyroid scan was stopped by local law enforcement because the patient set off a detection device in the cruiser. Apparently she was not treated well, given her medical condition and advanced age.

On March 20, 2003, a bus traveling from New York to Atlantic City set off a radiation alarm in a tunnel, as it passed by a radiation detector. When the State Police pulled over the bus, it was discovered that one of the passengers had received a 370 Megabecquerel (10 millicurie) dose of iodine-131 earlier that day from a medical procedure. Although the medical licensee provided the patient with written safety instructions, which included not using public transportation for 2 days, the patient failed to follow the instructions. This resulted in the activation of the radiation detector in the tunnel. Subsequent discussions with the patient's physician indicated that the patient's actions in taking the trip would have no safety significance to the members of the public on or near the bus. However, the event resulted in unnecessary concern and inconvenience to the patient and members of the public, as well as to law enforcement authorities and other public officials.

Discussion:
Heightened security measures are now in effect throughout the United States. These include, but are not limited to, installation of radiation surveillance equipment at critical infrastructures and mass congregation events. Therefore, types of incidents such as the one described within this IN are likely to increase for released patients that still contain detectable amounts of radiation from medical administrations of radiopharmaceuticals and brachytherapy sources.
These incidents may not be limited to those patients who are required to be provided written instructions, when released in accordance with 10 CFR 35.75, but could also include patients administered diagnostic dosages or low-level therapeutic dosages of radiopharmaceuticals. In the example above, if the patient had been administered less than 259 Megabecquerel (7 millicurie) of iodine-131, NRC regulations would not have required that the licensee provide the patient with written instructions, but the patient might still have set off a radiation detection alarm.
When licensees are required to provide written directions to patients released in accordance with 10 CFR 35.75, the licensees are expected to, among other things, review with authorized users the expectation that written instructions provided to patients will be followed. Accordingly, authorized users are expected to evaluate the patient's capability to follow recommended written instructions before release, to determine if release at that time is advisable, and stress the importance to the patient of following the written instructions.