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# Letter from the Editor

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## *Radiopharmaceutical Responsibilities*

Six months ago, the Nuclear Regulatory Commission (NRC) released a report concerned with misadministrations of the radioactive materials used in medicine for diagnosis and therapy. This report summarized the number, type, and cause of misadministrations. During an 18-month period ending June 1982, the NRC received a total of 693 reports involving 798 patients; 98% of the incidents involved diagnostic misadministrations.

The NRC report further revealed that 66% of the diagnostic misadministrations involved injections of the wrong radiopharmaceuticals. In 29% of the diagnostic misadministrations, the wrong patient had been injected. There were only three reports of therapeutic misadministrations of radiopharmaceuticals.

It is important to note that the NRC estimates that approximately 12 million nuclear medicine procedures were performed in the United States during this same period—and this indicates that the misadministration rate for nuclear medicine is in the range of 0.01%. Nuclear medicine technologists are to be congratulated for this. As the NRC report demonstrates, radiopharmaceutical misadministrations are rare. By contrast, the misadministration rate for non-radioactive pharmaceuticals to hospital patients is estimated to be anywhere from 11 to 22%.

It is my opinion that the NRC data demonstrate nuclear medicine technologists' diligence in handling radiopharmaceuticals and administering them to patients. We are conscientiously fulfilling our responsibilities to prepare, identify, and administer these materials properly. Nevertheless, we must continue to take care to use the appropriate radiopharmaceutical for the requested procedure on the correct patient.

Many individuals and professional organizations in the nuclear medicine community have expressed the opinion that it is not necessary to report misadministrations to the NRC because the incidence rate is extremely low and the NRC reporting system provides no benefits to patients. The Society of Nuclear Medicine is at this time working for technologists to request that the NRC withdraw or significantly revise the misadministration reporting requirements. Whatever the outcome of the Society's efforts, our continued attention is required to provide quality health care and maximum patient safety.



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Editor