September, 2024 – March, 2025 RAM NMED Events	
2 total events	
2 - Medical Event (Y-90)	
1.	On October 9, 2024 a patient was receiving a TheraSphere treatment. Prior to administration, the liver's segment 1 vessel was catheterized with a microcatheter by the Authorized User (AU). The catheter tip position was confirmed, the TheraSpheres administration box was assembled, and the treatment was performed according to the manufacturer's directions. The catheter flow was confirmed immediately prior to beginning dose administration. The first 10 ml saline flush proceeded without incident. However, after that, fluid started going into the overflow vial and the dosimeter reading did not decrease. These factors indicated that there was an obstruction preventing flow of TheraSpheres and saline into the microcatheter and the patient. This was also indicated by the AU observing an apparent cluster of TheraSpheres in the outlet tubing (between the source vial and the connection to the microcatheter). He lowered the outlet tube line to determine if the spheres could move forward. They did and they began to separate as they flowed downward, indicating they were not stuck together. The AU then attempted to complete the administration with multiple flushes. These did not succeed in pushing the visible spheres cluster from the outlet tubing into the microcatheter, and the overflow vial filled up with saline, so he stopped the administration (during each push the spheres cluster moved towards the microcatheter and the dosimeter reading dropped but following the push it returned to its previous position and the dosimeter reading to its previous value). The AU reported that, following the administration, the microcatheter tip was still properly positioned and there was no indication of a kink in the microcatheter. Standard monitoring of the administration area identified no contamination. Standard post-administration waste measurements and calculations were performed and determined that 32.7% of the prescribed activity (15.975 mCi) had been administered. The physician and the patient were informed on October 9, 2024 following the treatment. The patient was not harmed by the administration.
2.	On October 22, 2024 a patient was receiving a SirSphere treatment. During the course of administration of the Y-90 spheres in the IR suite, the microcatheter became blocked. The Authorized User (AU) and Sirtex representative contemplated disconnecting the microcatheter and running a wire through it to unclog the blockage. Out of fear of widespread contamination, they decided to terminate the procedure. The remaining dose/waste was assessed, and it was calculated that the patient received approximately 30 mCi out of a prescribed 50 mCi. This represents an approximate 40% underdose. The AU was satisfied with that amount, believing it to be therapeutic and does not expect any untoward effects to the patient.