Project to Collect Medical Near-Miss/Adverse Event Information

Medical Safety Information

June 2025

No.223

Medical Safety Information Highlighted in Quarterly Reports in 2024

The following provides an introduction to the titles of Medical Safety Information and major events highlighted in the Analysis of Recurrent and Similar Events section of the Project to Collect Medical Near-miss/Adverse Event Information's 76th–79th Quarterly Reports, which were published in 2024.
Detailed analyses of recurrent and similar events can be found on the project's website.

No.	Title	Quarterly Report No.
No.53	**Specimen mix-up at pathological diagnosis**	78th

◆ Specimen container mix-up

While preparing for prostate biopsies of Patients X and Y, the nurse put the specimen containers for both patients in the same place. As a result of the biopsy, Patient X was diagnosed with prostate cancer and underwent a radical prostatectomy, but no cancer was found in the surgical specimen. Medical staff subsequently discovered that the prostate biopsy specimens for Patients X and Y had been mixed up.

Types of mix-up	Situation	
	At specimen sampling (outside the pathological examination room)	At specimen handling (inside the pathological examination room)
Incorrect label attached	2	2
Mix-up of container with specimen	0	1
Mix-up of tissue when making the specimen	0	1

*Figure published in Medical Safety Information No.53

No.	Title	Quarterly Report No.
No.158	**Administration of a Sustained-Release Preparation in Ground-Up Form**	76th

◆ Administration of ground-up Nifedipine CR Tablets

The patient's oral intake was halted and the drug administration route switched to a nasogastric feeding tube. The nurse ground up the Nifedipine CR Tablets along with the patient's other oral medication and administered it via the nasogastric feeding tube. The patient's blood pressure subsequently fell into the 80 mmHg range.

◆ Sustained-release preparations are drug preparations in which the speed, duration, and site of the active ingredient's release are adjusted.

◆ Sustained-release formulations are indicated by letters in the name of the drug, such as L (long), LA (long-acting), R (retard), SR (sustained-release), and CR (controlled-release).

Image of a sustained-release preparation

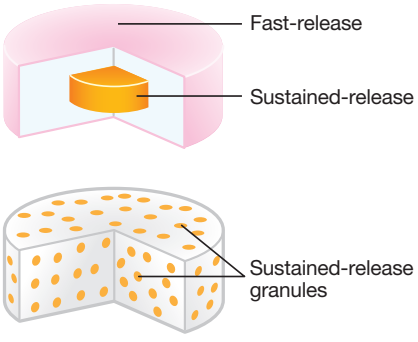

*Illustration published in Medical Safety Information No.158

Medical Safety Information Highlighted in Quarterly Reports in 2024

No.	Title	Quarterly Report No.
No.161	**Burns Caused by a Pulse Oximeter Probe**	78th

◆ Burns caused by continuous wearing of a pulse oximeter probe for long periods

At 06:00, the pulse oximeter probe became detached from a one-year-old pediatric patient, so Night Nurse A attached a new pulse oximeter probe. The ward had a rule that, while pulse oximeter probes were being used, the probe must be replaced every eight hours and the skin examined, but Day Shift Nurse B did not do this. At around 20:00, the pediatric patient began to cry and when Night Nurse C examined the patient, they found redness and induration on the right first toe. The physician examined the patient and diagnosed a low-temperature burn injury caused by a pulse oximeter probe.

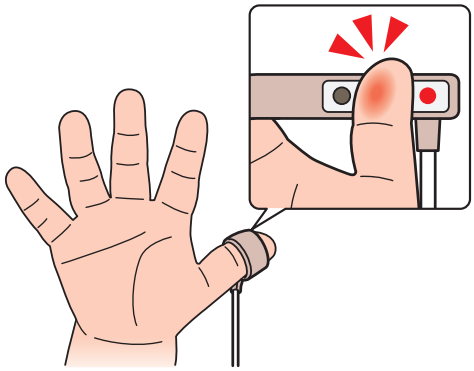

*Illustration published in Medical Safety Information No.161
*The site of the burn differs from that in the event described above.

No.	Title	Quarterly Report No.
No.171	**Reactivation of Hepatitis B Due to Immunosuppression/Chemotherapy**	79th

◆ Failure to regularly monitor the HBV DNA quantitative level

Administration of ibrutinib to the patient as chemotherapy for chronic lymphocytic leukemia was started. When starting ibrutinib, the patient was negative for the HBs antigen and positive for HBc and HBs antibodies, but the physician was not aware of the need for regular HBV DNA quantitative level monitoring and therefore did not carry it out. About 18 months after starting to take ibrutinib orally, the patient was examined in the emergency room due to vomiting. As a result of a thorough examination, the patient was diagnosed with a reactivation of the hepatitis B virus.

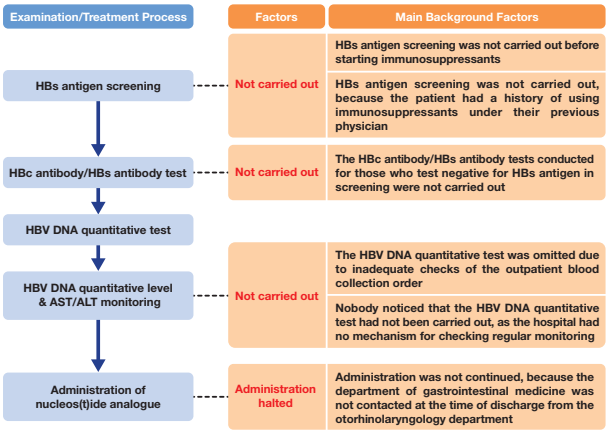

*Figure published in Medical Safety Information No.171

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the “Comprehensive Evaluation Panel” to prevent the occurrence and recurrence of medical adverse events. See the Project website for details.
https://www.med-safe.jp/
* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.
* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

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