

VA: 3 patients HIV-positive after clinic mistakes

April 19 2009, By BILL POOVEY , Associated Press Writer

(AP) -- Three patients exposed to contaminated medical equipment at Veterans Affairs hospitals have tested positive for HIV, the agency said Friday.

Initial tests show one patient each from VA medical facilities in Murfreesboro, Tenn.; Augusta, Ga.; and Miami has the virus that causes AIDS, according to a VA statement.

The three cases included one positive HIV test reported earlier this month, but the VA didn't identify the facility involved at the time.

The patients are among more than 10,000 getting tested because they were treated with endoscopic equipment that wasn't properly sterilized and exposed them to other people's body fluids.

Vietnam veteran Samuel Mendes, 60, said he was surprised to learn of an HIV case linked to the Miami facility, where he had a [colonoscopy](#). He was told he wasn't among those at risk.

"I was hoping and expecting to not get anyone contaminated like that," he said. "It's probably a little worse than we thought."

The VA also said there have been six positive tests for the [hepatitis B](#) virus and 19 positive tests for [hepatitis C](#) at the three locations.

There's no way to prove patients were exposed to the viruses at its

facilities, the agency said.

"These are not necessarily linked to any endoscopy issues and the evaluation continues," the statement said.

The VA has said it does not yet know if veterans treated with the same kind of equipment at its other 150 hospitals may have been exposed to the same mistake before the department had a nationwide safety training campaign.

An agency spokeswoman has said the mistake with the equipment was corrected nationwide by the time the campaign ended March 14. The problems discovered in December date back more than five years at the Murfreesboro and Miami hospitals.

The VA's disclosure Friday was the department's first comment since April 3, when the VA reported the one positive HIV test.

VA spokeswoman Katie Roberts has declined to provide any details on how widespread the problems might have been other than saying a review of the situation continues.

She said in an e-mail Friday that "there is a very small risk of harm to patients from the procedures at each site." She said the [HIV](#) results "still need to be verified" in additional tests.

The VA statement shows the number of "potentially affected" patients totals 10,797, including 6,387 who had colonoscopies at Murfreesboro, 3,341 who had colonoscopies at Miami and 1,069 who were treated at the ear, nose and throat clinic at Augusta.

More than 5,400 patients, about half of those at risk, have been notified of their follow-up test results, the VA said.

The Friday statement said the VA is "continuing to notify individuals whose letters have been returned as undeliverable, and working with homeless coordinators to reach veterans with no known home address."

The statement also said the VA has assigned more than 100 employees at the three locations to "ensure that affected veterans receive prompt testing and appropriate counseling."

All three sites used endoscopic equipment made by Olympus American Inc., which has said in a statement it is helping the VA address problems with "inadvertently neglecting to appropriately reprocess a specific auxiliary water tube."

Charles Rollins, 62, who served three tours in Vietnam with the Navy from 1966 to 1969, said the news concerns him because he's used the Augusta ear, nose and throat clinic several times.

"That's terrible," he said by phone as he socialized at an American Legion post in Augusta.

Associated Press writers Lisa Orkin in Miami and Dorie Turner in Atlanta contributed to this report.

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