Doctor: HIV infections will never be traced to VA

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This May 4, 2009 photo shows two water tube connectors used on endoscopic equipment at the Alvin C. York Veterans Administration hospital in Murfreesboro, Tenn. The one on the left is a one-way valve and does not allow for fluid to flow back through the tube. The one on the right is a two-way valve and does allow the backflow of fluids. The one-way valve is the one that should be used during a colonoscopy. A top doctor at the U.S. Department of Veterans Affairs predicts former patients who have tested positive for HIV or hepatitis will never be able to show that they were infected by, or even exposed to, endoscopic equipment mistakes at VA medical centers. (AP Photo/Mark Humphrey)

(AP) -- Former patients who tested positive for HIV or hepatitis will not be able to show they were infected by tainted equipment at U.S. Department of Veterans Affairs hospitals, a top doctor for the agency said Friday.

Dr. Jim Bagian, the VA's chief patient safety officer, said the patients won't be able to prove they were even exposed to endoscopic equipment that wasn't properly sterilized. The equipment is used for colonoscopies and ear, nose and throat procedures. It was discovered in December that equipment was either not properly cleaned or set up.

Five patients have tested positive for HIV and 33 have tested positive for hepatitis since February, when the VA started notifying more than 11,000 people treated at three VA medical centers to get follow-up blood checks because they could have been exposed to infectious body fluids. The hospitals are in Miami, Murfreesboro, Tenn., and Augusta, Ga.

The blood tests are continuing. The agency has stressed that the positive results for the diseases may not have come from the VA's problems with dirty equipment.

"At this point I don't think we'll ever know" how the patients were infected, Bagian said.

Some veterans and members of Congress want more explanation than that.

"Some of them did not have these infections before their colonoscopies," said Mike Sheppard, a Nashville lawyer representing some former VA patients who tested positive for HIV and hepatitis.

Sheppard said the only way to find out how the infections were

contracted is by examining all medical records - all of which are in the hands of the VA.

The U.S. House Committee on Veterans Affairs has tentatively set a June hearing for the VA inspector general to report on a review of the mistakes.

A spokesman for the American Society for Gastrointestinal Endoscopy said although the patients recently tested positive, they could have had the viruses for years - and before the VA treated them - without showing symptoms.

"I don't believe there is going to be any way to definitively link their HIV positive status to the facility," Dr. David A. Greenwald said Friday in a telephone interview from the Montefiore Medical Center in New York.

The initial December discovery of an equipment mistake at Murfreesboro led to a nationwide safety "step-up" by the VA at its 153 medical centers. Since then, the problems have been discussed with staff at all VA hospitals and with representatives of the equipment manufacturer.

"We look at these as our patients," Bagian said. "We are not going to quibble about 'Was it caused because you are an IV drug user?' ... Suppose it was drug use. We are still going to treat them anyway."

Bagian said it would "be being a weeny or gutless jerk to try to hide behind it. The point is, take care of the patient."

Each of the three centers had a different problem operating the same kind of equipment made by Olympus American, according to the VA. In Murfreesboro, the equipment was incorrectly rigged because of a mix-up

and may have allowed body fluid residue to transfer from patient to patient.

Bagian said the VA doesn't know how frequently that happened after the equipment was installed in 2003.

In Miami, a tube that was supposed to be cleaned after each colonoscopy was instead cleaned at the end of each day, Bagian said. And in Augusta, the ENT scopes used for looking into the nose and throat weren't properly cleaned. Everyone who may have been exposed because of those problems was notified.

All the problems were human error, he said.