VA halts surgeries at St. Louis hospital

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(AP) -- The VA Medical Center in St. Louis halted surgeries indefinitely this week after a regular inspection showed possible contamination of equipment, the hospital's medical director said Thursday.

RimaAnn O. Nelson said spots were noticed on surgical trays and water stains on at least one surgical instrument before any surgeries were performed Wednesday. She said hospital officials have since inspected all other surgical materials and had vendors at the center Thursday inspecting and testing all surgery-related equipment.

Nelson did not say how many patients might be affected or when surgeries might resume.

"VA will work with all affected veterans to reschedule surgical appointments or arrange for alternate care in any urgent cases," Nelson said in a statement.

The episode is the latest case of sterilization problems at the John Cochran VA Medical Center.

Last year, the VA notified 1,812 veterans who were treated at the center's dental clinic from Feb. 1, 2009, through March 11, 2010, that they might have been exposed to HIV, hepatitis B and hepatitis C because of improperly sterilized dental equipment. They were urged to be tested for the diseases.

The VA announced in July that of 1,022 veterans who were tested and

told of the results following the alert, two tested positive for hepatitis B and two for hepatitis C. The agency later said no known cases of disease were linked to the sterilization problem.

St. Louis VA medical facilities provide services for veterans in Missouri and Illinois. The U.S. House Committee on Veterans Affairs held hearings on the situation at the St. Louis center in July.

U.S. Rep. Russ Carnahan, a Democrat from St. Louis who announced his appointment to the committee Thursday, has been especially critical of the medical center's response to the contamination problems.

"How many times does something have to happen before they fix this facility?" Carnahan said in a statement. "Clearly the problems there go well beyond one department. It's time for a full, top-to-bottom, independent review of the entire facility. It needs to happen and it needs to happen now. The health and safety of our veterans is too important to wait."

In 2009, the Department of Veterans Affairs notified about 10,000 veterans who were treated at VA hospitals in Augusta, Ga., Miami and Murfreesboro, Tenn., that they may have been exposed to infections during colonoscopies or other endoscopic procedures where equipment had been improperly cleaned.

More than 50 subsequently tested positive for infections - including at least eight who tested positive for HIV. The VA said at the time it was impossible to tell where those infections came from, but it is offered free medical treatment to all those affected.

In a follow-up, the VA's inspector general reported in September 2009 that the department's medical facilities had made significant progress on fixing endoscopic procedure problems. The report said surprise visits to

128 medical facilities found all of them compliant in following procedures.