Wis. clinic warns of possible disease exposures

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(AP) -- A Madison-based clinic is trying to track down hundreds of patients after a nurse apparently spent years improperly using diabetic injection devices on them, potentially exposing them to blood-borne diseases such as HIV.

Dean Clinic officials on Monday began trying to contact by phone and letter 2,345 patients who saw the nurse between 2006 and when she left her job two weeks ago. They want the patients to come in for testing for HIV as well as hepatitis B and C. State and local health officials said they're monitoring the situation, but no one had detected any diseases connected to the nurse as of late Monday afternoon.

The clinic's chief medical officer, Dr. Mark Kaufman, said the nurse is a certified diabetic educator. Her job called for her to train newly-diagnosed diabetics on how to inject insulin and test their blood sugar levels.

Clinic officials declined to identify the nurse.

Earlier this month, another clinic employee reported that the nurse was improperly using a device known as an insulin demonstration pen, which resembles a large hypodermic needle and injects insulin into the bloodstream, as well as a more widely-known finger prick device for blood tests, Kaufman said.

The nurse was supposed to demonstrate how to use the pen on pillows

and oranges, not on the patients themselves, Kaufman said. But an internal investigation showed she was using the same pen on people. She used clean needles each time, but using the pen on a person could allow a microscopic backwash of blood to flow back into the pen's reservoir, potentially contaminating it and putting the next patient at risk, Kaufman said.

The finger prick device is supposed to be used on people, but the entire device should be used only once per patient, Kaufman said. The nurse changed needles but used the same handle from patient to patient, creating a risk that blood could get onto it, dry and infect the next fresh needle and patient.

The nurse left her job on Aug. 10, the same week the other clinic employee came forward about her practices, said Dr. Craig Samitt, the clinic's chief executive officer. He declined to say whether she resigned or was terminated.

Samitt and Kaufman said the nurse was experienced, noting her certification as a diabetic educator, but it's unclear why she didn't follow the devices' guidelines or clinic protocols. Clinic officials have interviewed her, but Samitt declined to elaborate.

"This is an ongoing investigation," he said.

Kaufman said the nurse's actions probably pose little danger to the patients. The HIV virus degrades in a matter of days, and the hepatitis strains can't survive for more than a month, he noted.

It's unclear just how many of the nurse's patients underwent an insulin pen or finger prick demonstration or even if anyone who did was infected with a blood disease and could have passed it on.

"The risk is minimal, but remains a theoretical risk," Kaufman said.

Dean Clinic includes about 720 health care providers located throughout southern Wisconsin. Samitt declined to say where the nurse worked.

Stephanie Smiley, a spokeswoman for the state Department of Health Services, said agency officials learned of the potential exposures Monday morning and have been in contact with the clinic. They also have notified the U.S. Centers for Disease Control and Prevention, she said.

"This is a very serious situation and it appears that Dean Clinic is taking the appropriate steps to notify patients of possible exposure and performing follow-up testing as necessary," she said in an email.

A CDC spokeswoman had no immediate comment. Officials with the state Department of Safety and Professional Services, which regulates health care providers, declined comment.

In the last few years, poor hygiene practices at U.S. Department of Veterans Affairs hospitals in Ohio, Florida, Georgia, Missouri and Tennessee led to warnings to nearly 13,000 veterans that they should be checked for possible blood borne diseases.

Tests so far have found eight possible infections with HIV, the virus that causes AIDS, and 61 cases of hepatitis B or C, the VA has said. However, it's not known how many of these cases, if any, were from treatment at VA hospitals or from unrelated causes. Testing often is unable to determine the origin of such infections, and some people may have been infected before their VA care occurred without knowing it.

Hepatitis C infections also can resolve on their own over time. Certain medicines can help the body clear the virus - why it's important for

anyone at potential risk to be tested as soon as possible.

It's not known how common infection breaches like this are at private hospitals. The VA ones came to light because the VA is a government entity and must report such incidents.