

## HIV risk at Miami VA hospital not found until 2nd review

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The Miami Veterans Affairs hospital, which may have exposed thousands of veterans to HIV and hepatitis by using improperly sterilized colonoscopy equipment, gave itself a clean bill of health in January, only to discover problems two months later after a more intensive review, VA officials told U.S. House members in a closed-door briefing Thursday.

The green light came weeks after the Department of Veterans Affairs, in a Dec. 22 alert, warned veterans hospitals nationwide to check for problems associated with colonoscopy equipment. The alert followed similar reported problems at a Tennessee VA clinic that also could have exposed thousands of veterans to hepatitis and HIV.

The Miami hospital reported it was in the clear, only to discover during a more thorough review in March that endoscopic equipment was not being sanitized as the manufacturer recommended. The VA had asked all medical centers to perform a more comprehensive review in mid-March, said Katie Roberts, VA spokeswoman in Washington.

That finding prompted the hospital to send out a letter Monday, alerting about 3,260 people who may have had colonoscopies at the center between May 2004 and March 12, 2009.

Miami VA spokeswoman Susan Ward declined to comment Thursday, and Dr. John Vara, the Miami VA's chief of staff, could not be reached. Roberts confirmed the timeline.

"When the Dec. 22 patient safety alert came out with its questions about processes, there was just this initial response by Miami that 'we're OK,'" Roberts said.

She said the department was conducting an internal investigation and that employees could face disciplinary action if there was cause. "We don't take this lightly," she said.

Members of Congress on Thursday promised hearings into the matter and said they still had questions after the hourlong briefing.

"The more you know, the more you worry about," said Rep. Ileana Ros-Lehtinen, R-Miami, who provided details of the meeting. She was one of several South Florida members to attend the briefing convened by U.S. Rep. Steve Buyer, R-Ind., the top Republican on the House Committee on Veterans' Affairs. She was particularly troubled about the timeline that VA officials provided.

Buyer said he is concerned that the Miami case comes on the heels of problems at VA hospitals in Georgia and Tennessee.

"I want the VA to tell us why routine procedures were not in place," Buyer said.

William E. Duncan, M.D., associate deputy under secretary for health quality and safety, said in a statement, "We feel that the risk of cross-contamination among patients is small, and many patients are at no risk whatsoever."

"Our proactive monitoring program caught this problem. It's part of our efforts to ensure that veterans who get their care from VA receive the best care available anywhere," he added.

U.S. Rep. Kendrick Meek, D-Miami, whose district includes the hospital, said the VA has said it plans to send a team to the Miami hospital to ensure it is complying with proper protocol.

Meek sent out a news release about the problem Monday, after he was alerted to it by the VA. He plans to tour the hospital Friday morning. "There's only a small likelihood that anyone could be infected, but there is a possibility," Meek said. "The veterans are very concerned, for themselves and their families."

The Miami problem arose when the tubing, pump and reservoir used in the colonoscopy procedure were rinsed after use but not disinfected as required by the manufacturer. It created a slight chance that back-flow from the pump could carry tiny amounts of virus into the patient.

As of Wednesday, the Miami VA had received 4,300 calls, and about 912 patients had undergone testing, though only 500 were in the at-risk pool of those receiving colonoscopies between May 2004 and March 12. Also, 55 VA employees are in the risk pool of 3,260 people.

As many as half the people in the risk pool may have zero risk because the flushing system identified as the problem was not used or attached during their procedure, but the VA doesn't know which people that includes, so it is offering testing to everyone.

Asked whether anyone in the risk pool carried any infectious disease, the VA suggested that as many as 100 had previously been diagnosed with HIV before getting VA colonoscopies -- creating a slight chance that they could have inadvertently infected others..

Since December, the VA has revealed similar problems with colonoscopy equipment at VA clinics in Murfreesboro, Tenn., and Augusta, Ga. On Thursday, it said 10 of the 6,400 veterans exposed in Murfreesboro and six of the 1,100 veterans exposed in Augusta have since tested positive for viral infection. The 10 who tested positive in Murfreesboro were infected with hepatitis B or C -- none with HIV, a VA spokeswoman said. She didn't have the breakdown for veterans in Augusta.

"There is no way to determine if the positive test results are directly related to the endoscopies at each facility," said VA southeast regional spokeswoman Jan Neethan, noting that members have been infected before the procedure on other means. She said the VA received 4,200 phone calls reporting concerns from

Northstar, noting they may have been infected before the procedures or by other means. She said the VA received 4,300 phone calls requesting screening from veterans in Murfreesboro and 675 from Augusta.

"In both Murfreesboro and Augusta, some veterans have declined tests or gotten tested in private healthcare facilities, so we cannot specify the overall number of veterans who were tested," Northstar said. "VA clinicians and infectious-disease experts are working with each veteran to create a plan of care based on their individual results."

Miami VA officials have assigned additional staff to the Special Care Call Center for Veterans to ask questions or schedule testing. Veterans should call 305-575-7256 or 877-575-7256.