Congressional Panel Examines VA HIV Exposure Case

June 15, 2009

A congressional panel in Washington, DC, on June 16 will urge the Department of Veterans Affairs to explain whether improperly sanitized equipment that may have exposed 10,000 veterans to HIV and other blood-borne illnesses was isolated to three Southeast facilities or if the problem is more widespread, The Associated Press(AP) reports.

“Somebody is going to have to take responsibility,” said U.S. Representative Phil Roe of Tennessee, the ranking Republican on the House Committee on Veterans Affairs’ oversight and investigation subcommittee.

According to the article, as of June 12, unsterilized endoscopic equipment used for colonoscopies and other medical procedures has been linked to six HIV cases among veterans treated since 2003 at VA hospitals in Miami; Murfreesboro, Tennessee; and Augusta, Georgia. In addition, 34 tested positive for hepatitis C and 13 for hepatitis B. All but 724 of the 10,000 at-risk patients have been notified of their test results.

Although the patients recently tested positive for HIV and other infections, it is possible that they were living with these illnesses before receiving VA treatment, said David A. Greenwald, MD, a spokesman for the American Society for Gastrointestinal Endoscopy. He added that the positive tests for HIV and hepatitis C reported by the VA are below the frequency of positive tests from studies of other groups of veterans.

“Probably all of the infections that are being reported are infections people already had,” Greenwald told the AP.

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