Another Insulin Pen Infection At NY Hospital

(AP) — A second western New York hospital is notifying patients that they may have been exposed to HIV, hepatitis B or hepatitis C through the improper sharing of insulin pens, hospital officials said Thursday. Olean General Hospital was mailing letters to 1,915 patients who received insulin at the hospital from November 2009 through last week, advising them to call to arrange for blood testing. The risk of infection is very low, hospital officials said, but they wanted patients to be aware of the possibility.

Hospital officials said the action follows an internal review conducted after the Veterans Affairs hospital in Buffalo discovered more than 700 patients may have been exposed to blood-borne pathogens over a two-year period when multi-use pens intended for use by a single patient may have been used on more than one person. "Interviews with nursing staff indicated that the practice of using one patient's insulin pen for other patients may have occurred on some patients," said Timothy Finan, president and chief executive of Upper Allegheny Health System, the parent company of the Olean hospital.

Olean General had not identified any specific patients who may have received an injection from another patient's pen and knew of no cases of infection, Finan said in a news release. "Regardless, to the extent there may be a chance, however remote, that any patient was provided insulin from an insulin pen other than their own, Olean General Hospital has decided to be proactive and aggressive with respect to notification of our patients," the release said. As was the case in Buffalo, needles were changed with each use of the insulin pens, the Olean hospital said. The risk of infection remained, however, because stored insulin in the pen cartridge could have become contaminated by a back flow of blood with each use.

"We are very aware that while the risk of infection from insulin pen re-use is extremely small, cross-contamination from an insulin pen is possible," Finan said. Federal health agencies have been warning against sharing insulin pens for several years. The Food and Drug Administration issued an alert in March 2009 after learning that more than 2,000 patients may have been exposed at a Texas hospital between 2007 and 2009. A clinical alert from the Centers for Disease Control and Prevention last year came amid continued reports of the practice.

The pens have been removed from use at Olean General. They were never used at a second hospital in the Upper Allegheny Health System, Bradford Regional Medical Center in Pennsylvania, Finan said. Revelations of the issue at the VA hospital led the Department of Veterans Affairs Inspector General to initiate a review of the Buffalo hospital.

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