

Hepatitis C Community Forum

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Identification of the cluster

- January: 3 acute cases identified

State of Nevada
Confidential Morbidity Report Form Updated January 2007

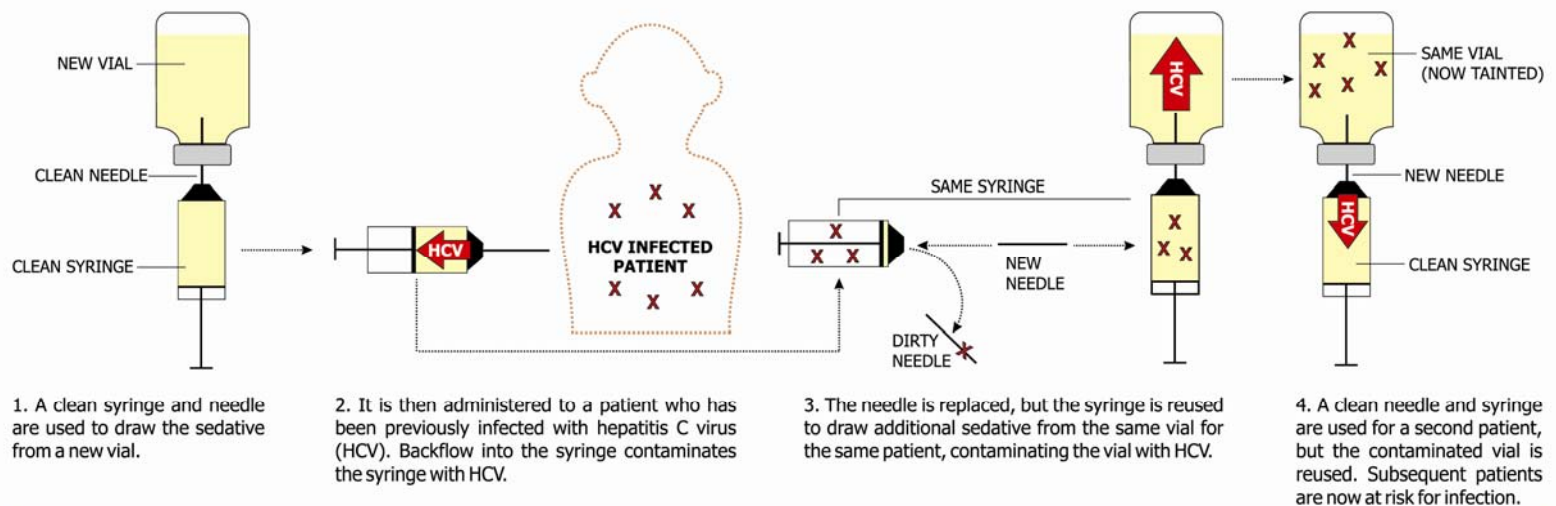


Provider	Attending Physician		Physician Phone	Physician Fax
	Person Reporting / Job Title		Reporter Phone	Reporter Fax
	Facility Name		Facility Phone	Report Date
Patient	Name		Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other
	Address	County	Transgender <input type="checkbox"/> No <input type="checkbox"/> Yes, MF <input type="checkbox"/> Yes, FM	
	City	State	Zip	Pregnant <input type="checkbox"/> No <input type="checkbox"/> Yes

How it happened

Unsafe Injection Practices and Disease Transmission

Reuse of syringes combined with the use of single-dose vials for multiple patients undergoing anesthesia can transmit infectious diseases. The syringe does not have to be used on multiple patients for this to occur.



Investigation results

- 7 known acute cases (to date)
 - 6 linked to one location/4 share common source
- Unsafe practices occurred over time
- Anesthesia logs show fewer vials used than patients treated
- Clinic staff interviews support investigation findings
- Cannot positively link all new cases to the clinic

What's next

- Investigation continues
- Patient interviews
- Medical records
- Policy recommendations