State Health and Nassau County Departments Notify Patients of Possible Risk of Hepatitis C Exposure

Albany, N.Y. (November 13, 2007) - Approximately 630 patients who received injections from a physician who worked at two clinics in Nassau County have been alerted this week by letter from the state and Nassau County health departments that they should be tested for hepatitis C, hepatitis B and Human Immunodeficiency Virus (HIV) infections. This notification is based on a joint investigation by the state and county health departments that confirmed transmission of hepatitis C infections between at least two of the physician's patients that was likely from the reuse of syringes in vials of medicine used on multiple patients during injections.

The investigation found that transmission did not occur from physician to patient but was the result of lapses in infection control. While the risk of transmission is very low, state and county health officials advise patients receiving letters to get tested, even if they do not feel ill. The lapses in infection control practices noted by this physician may have placed any patient receiving an injection at risk for certain viral infections. Patients who received injections from the physician at the two clinics between January 1, 2000 and January 15, 2005, are being notified by letter.

"Transmission of hepatitis in a medical setting is rare, but as a precaution we are reaching out to anyone who could have potentially been exposed," said state Health Commissioner Richard F. Daines, M.D., "We are contacting all potentially exposed individuals to advise them to seek testing. If you have received a letter from us about this situation, it is important that you contact your doctor to get tested."

Hepatitis C is a liver disease caused by the hepatitis C virus (HCV), which is found in the blood of persons who have this disease. HCV is spread by contact with the blood of an infected person.

As of January 15, 2005, the state Health Department determined that the physician's lapses in infection control had been corrected. The doctor continues to practice. The state Health Department is not releasing the physician's name or the names of the clinics.

.vestigation Background

In January 2005, two cases of hepatitis C infection were identified through routine surveillance by the Nassau County Department of Health; both cases received injections from the same physician. Investigators believe that the reuse of syringes in vials used on multiple patients caused this transmission of hepatitis C infection. Extensive review of practice records determined anyone who received an injection from this physician at either of the two clinics before January 15, 2005 and after January 1, 2000 may be at risk for hepatitis C infection. Although cases of hepatitis B or HIV infection have not been linked to this physician's techniques or these clinics; patients are recommended to also be tested for these infections.

People NOT receiving a letter and who are patients of this physician are NOT at risk as part of this notification and should consult with their health care provider if they have questions.

Physicians and other health care providers in New York must undergo mandated education periodically in proper infection control procedures. When renewing their licenses, physicians must acknowledge completing training within the past four years. Injections are very safe when standard infection control procedures are followed.

If you received a letter and may be at higher risk of transmission, please be aware that:

- Spread of HIV through injection is uncommon, and **NO** HIV infections have been linked to this physician's techniques or these clinics. However, the state and county health departments are recommending HIV testing as well as hepatitis B and C testing, because HIV can be transmitted by blood.
- Patients who have never been diagnosed with hepatitis B or C, or HIV need to be tested.
- The state Health Department has established an information hotline for patients receiving letters, open from 8:30 a.m. to 8 p.m. Monday through Friday and from 9 a.m. to 5 p.m. Saturday and Sunday.

Please visit the Department of Health website at www.nyhealth.gov for more information on hepatitis C, hepatitis B and HIV infection.

Statement by State Health Commissioner Richard F. Daines, M.D.

'hany, N.Y. (November 14, 2007) - When the State and Nassau County Health Departments first became aware of o cases of hepatitis C related to a L.I. physician's practice, they took immediate action to identify patients at risk of infection because they had had injections from this doctor during the time period of the transmission. The Department first advised patients in May 2005 to be tested for hepatitis C, hepatitis B and HIV, all of which can be transmitted by blood.

The investigation identified 98 patients that were notified by letter of the need for testing due to possible risk of transmission, and 84 of them were tested by the state's Wadsworth lab utilizing a new testing procedure that had not been used before. Laboratory evidence from December 2005 found two hepatitis C cases.

The state health department promptly contacted the physician, who was then observed by the state and county investigators using improper infection control procedures. The doctor was immediately formally notified by the state to cease the improper infection control practices. The doctor was then instructed in the proper infection control procedures and has agreed to have his infection control procedures monitored by the state.

The Health Department then expanded its investigation to include all patients who had received injections from this anesthesiologist for the five years prior to January 15, 2005, when the state confirmed that the physician was practicing proper infection control practices.

The Health Department identified all patients who had received injections between January 1, 2000 and January 15, 2005 after a thorough review of medical records of this physician. These patients received letters this week advising them to be tested for hepatitis C, hepatitis B and HIV.

While chance of transmission is low, it is important that every patient be made aware of facts that might affect their health so that they can act appropriately.

Revised: November 2007

Statement from Health Commissioner Richard F. Daines

'bany, N.Y. (Nov. 20, 2007) - As a result of the State Department of Health's ongoing investigation into the practices Long Island anesthesiologist Harvey Finkelstein, the Department has determined that there are a number of patients in his practice who have not yet been notified of the need for testing.

The state Health Department staff has spent the past several days reviewing the doctor's office records and billing systems. Based on the results of this review, we now advise that **all patients who believe they received an injection before January 15, 2005, from Dr. Harvey Finkelstein in the Pain Clinic of Long Island or the Island Orthopedic Sports Medicine Center should be tested for hepatitis C, hepatitis B and HIV**. As we continue to review these records, we will also send individual notification letters to all identified patients. Patients as described above who have not received letters should call the state Health Department at **1-800-278-2965** so that they may receive an information packet.

Revised: November 2007

Statement by Health Commissioner Richard F. Daines, M.D.

BANY, N.Y. (Dec. 14, 2007) – Back in November I urged all patients who believe they received an injection before .nuary 15, 2005, from Dr. Harvey Finkelstein in the Pain Clinic of Long Island in Plainview or the Island Orthopaedics Sports Medicine Center in Massapequa to be tested for hepatitis C, hepatitis B and HIV. Since that time the Department was able to obtain billing records from Dr. Finkelstein for these two practice sites.

Today, we are taking the extra precaution of mailing important information to 8,500 patients who were treated by Dr. Finkelstein at these sites. It is important to understand that not every patient who receives this letter is at risk of infection. The billing records do not allow us to determine who received an injection and who did not. We are urging those who did receive an injection to be tested. Those who did not receive an injection do not need to be tested. I wanted to follow up on my earlier public announcement to take this additional step to ensure that people have the information they need and everyone who should be tested gets tested. A positive test result does not mean the patient contracted the disease through Dr. Finkelstein's practices.

I also want to reassure the public that the testing results so far do not indicate an excessive number of hepatitis C cases. Typically, each month there are about 95 reports of new acute and chronic hepatitis C cases in Nassau County. Nassau County has performed preliminary testing of 133 of Dr. Finkelstein's patients and has shown 2 new preliminarily positive patients for hepatitis C and one previously known case (an rate of about 1.5%). It is estimated that at any time, approximately 1.6% of the general population will test positive for hepatitis C. We have also learned that there were four cases of hepatitis C identified among those patients of Dr. Finkelstein's patients who were tested by their private physicians. These testing results appear to be within the range of what would normally be expected. I also want to stress that we know of NO cases of acute or chronic hepatitis B or HIV transmission as a result of Dr. Finkelstein's practices.

The Health Department continues to provide assistance to Dr. Finkelstein's patients and answer their questions 24 hours a day, seven days a week.

Revised: December 2007

Nassau County and State Health Departments Alert 36 Patients to Infection Control Error by Long Island Doctor

ALBANY, N.Y. (Jan. 15, 2008) –Thirty-six patients of Nassau County obstetrician/gynecologist E. Jacob Simhaee will receive letters this week alerting them to an infection control error that occurred when they got flu shots last fall at his office at 1201 Northern Blvd., Manhasset.

The error, which involved reuse of syringes, but not needles, containing influenza vaccine for multiple patients, occurred between September and December 2007. No disease transmission of any kind has been identified.

In the investigation that began a month ago, the New York State Department of Health and the Nassau County Department of Health determined that a single syringe was, at times, used to hold up to six doses of flu vaccine, with fresh needles used for each patient. Standard infection control procedures require that a new syringe be used for each patient as well.

Dr. Simhaee and his staff have assisted the departments' action to identify at-risk patients and actively contact, counsel, and facilitate testing to ensure proper management of this incident. All patients determined to be at risk are being notified by phone and by letter of the lapse in proper vaccination technique. The U.S. Centers for Disease Control and Prevention has said that the risk of transmission of the blood-borne diseases hepatitis B and C and HIV is believed to be extremely low in such a case.

The state and county health departments recommend that these patients be tested for the three viruses and re-vaccinated against the flu. The vaccine may not be as effective as it would have been if all infection control standards had been followed. Dr. Simhaee is offering testing and re-vaccination in his office.

The Health Department noted that Dr. Simhaee cooperated fully with the patient notification effort. State health officials approved the letter Dr. Simhaee mailed to his patients, provided fact sheets on the viruses and will confirm receipt of the letters.

The State Health Department is reviewing the content and frequency of the current required infection control training certification to make it more effective.

Revised: January 2008