



PRESS RELEASE

FOR IMMEDIATE RELEASE

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MISIDENTIFICATION OF ONE LAB SPECIMEN

BETHESDA, MD – At Walter Reed National Military Medical Center (WRNMMC) we strive for and practice transparency and strongly believe that our beneficiaries' well-being is our highest priority as they are the primary decision makers for their health care.

In October 2013, we sent 150 routine blood specimens to a Department of Defense-contracted reference laboratory for HIV testing. One of these specimens tested positive for HIV. The patient with the positive test result was referred for medical care that involved two subsequent verification tests. These test results were negative which led us to believe the specimen had been misidentified.

The Navy Bloodborne Infection Management Center immediately opened an investigation of this incident. WRNMMC Pathology Department determined that due to the blood type of the specimens involved, there were 72 patients who needed to be retested. We sent letters via certified mail to these patients to inform them that there had been a specimen misidentification, and that despite the original reported HIV negative test result there was a possibility that they were the patient who tested HIV positive. The letter encouraged the patients to return to the nearest treatment facility for repeat testing.

Today, 63 patients have responded and are in the process of being retested; only nine patients have not responded to our efforts to contact them. We will continue to make every effort to contact them and re-do their tests. Additionally, our main lab continues to track all patients, monitoring which have been effectively contacted, which have had repeat samples collected, and the results of the subsequent test.

We will continue our efforts to contact the remaining nine patients until we identify and retest the one person whose sample was positive. This remains our highest priority, as well as maintaining full transparency throughout this process.

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