A worker for a laboratory doing research has become infected with the Human Immunodeficiency Virus (HIV), the agent that causes AIDS. The worker has no known risk factors and investigators are unsure how the individual came to test positive for the disease.

Hundreds of other laboratory workers who work with the AIDS virus are tested regularly and none has become infected. The laboratory in question produced and worked with highly concentrated AIDS virus unlike the concentration found anywhere outside a laboratory and a mishap in laboratory procedure is one avenue being explored by scientists. The virus isolated from the worker was found through recent specific tests to be identical to the strain of HIV being grown in the laboratory.

Because of the many variants of HIV in nature, it is considered unlikely that the individual was infected from a source other than the laboratory. How the infection occurred is currently being investigated.
This is the text of a news release that the Department issued late Friday (after 5), Sept. 11. Dr. Fischinger was the contact name placed on the release. He is our one and only spokesman on this.

Linda

9/11/87

WE1 never got the release NFS never release paper - so please keep this in KRS for the record.
After a preliminary review of information provided by a worker who became infected with an AIDS virus, a team of virus safety experts have identified a series of occurrences that could have caused the worker to come into direct contact with the virus.

The site at which the exposure apparently occurred was a non-governmental research facility that works with highly concentrated AIDS virus.

The team reviewing the incident comprised experts from the National Institutes of Health, the Centers for Disease Control, and other investigators. The infected worker—who is currently symptom free—cooperated fully in discussions with one member of the reviewing team on the condition that the person's identity would not be disclosed.

The worker said that leakage from medical instruments containing the virus had occurred, and that seals for the laboratory's centrifuge rotor had failed on occasion. The outer shells of those rotors could have been contaminated with the virus at times.

The worker carried out a variety of procedures associated with the production of viruses.

The worker reported having worked with the virus in containment facilities during times when skin abrasions, cuts, or dermatitis were present, although gloves were always worn when the virus was handled.
The preliminary opinion of the reviewing team was that the most likely reason for the worker's infection was direct contact with highly concentrated virus. They noted that more than 400 other laboratory personnel who work with highly concentrated AIDS virus have been monitored and none has become infected. The team judged the currently used level of containment in laboratories to be adequate provided there is strict adherence to recommended procedures.

The team is currently visiting NIH contract facilities engaged in the production of the AIDS virus and those engaged in producing the AIDS test kit to review their compliance with the CDC/NIH biosafety guidelines.