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**A Patient Safety Threat – Syringe Reuse**

Related Pages

Important Information!

Please read this fact sheet if you have received a letter stating that you may be at risk due to syringe reuse by your healthcare provider.

Patients need to be aware of a very serious threat to their health – the reuse of needles or syringes, and the misuse of medication vials. Healthcare providers (doctors, nurses, and anyone providing injections) should **never reuse a needle or syringe** either from one patient to another or to withdraw medicine from a vial. Both needle and syringe must be discarded once they have been used. It is not safe to change the needle and reuse the syringe – this practice can transmit disease.



A single-use vial is a bottle of liquid medication that is given to a patient through a needle and syringe. Single-use vials contains only one dose of medication and should only be used once for one patient, using a clean needle and clean syringe.



Figure 2. Picture of a multi-dose vial.

A **multi-dose vial** is a bottle of liquid medication that contains more than one dose of medication and is often used by diabetic patients or for vaccinations. A new, clean needle and clean syringe should always be used to access the medication in a multi-dose vial. Reuse of needles or syringes to access medication can result in contamination of the medicine with germs that can be spread to others when the medicine is used again.

Whenever possible, CDC recommends that single-use vials be used and that multi-dose vials of medication be assigned to a single patient to reduce the risk of disease transmission.

Healthcare providers should always adhere to [**Safe Injection Practices**](https://www.cdc.gov/injectionsafety/ip07_standardprecaution.html) under [**Standard Precautions**](https://www.cdc.gov/injectionsafety/ip07_standardprecaution.html) to prevent disease transmission from needles, syringes, or multi-dose vials.

Reusing a needle or syringe puts patients in danger of contracting [Hepatitis C](https://www.cdc.gov/hepatitis/hcv/index.htm%20), [Hepatitis B](https://www.cdc.gov/hepatitis/hbv/index.htm), and possibly [HIV](https://www.cdc.gov/hiv/). When it is discovered that reuse of a needle or syringe has occurred, all patients who may have been affected should be notified and informed to get tested.

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