COMMUNICABLE DISEASES INTELLIGENCE

ISSN 0725-3141 VOLUME 16 NUMBER 13 29 June 1992

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COMMUNICABLE DISEASES NETWORK-AUSTRALIA
A National Network for Communicable Diseases Surveillance

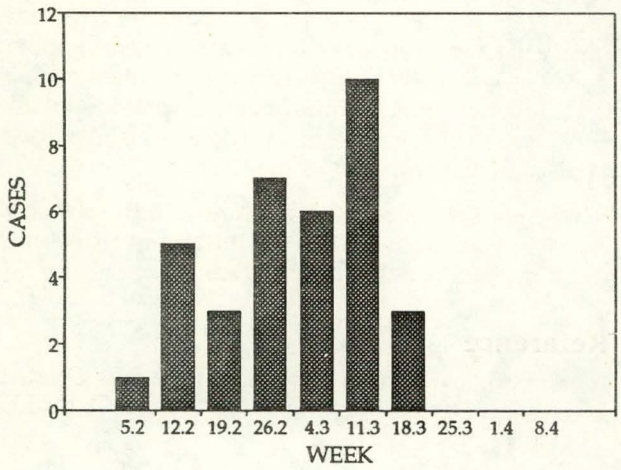
AN OUTBREAK OF MEASLES IN CAIRNS

(Tropical Centre for Disease Control, Cairns, Queensland)

In early March, measles was diagnosed in a child inpatient in Cairns Base Hospital. As an immediate measure, the ward contacts of the child were immunised with measles-mumps-rubella (MMR) vaccine unless there was a clear record of prior MMR immunisation.

Local general practitioners were contacted by phone and asked about recent diagnoses of measles as was the Medical Director of the Casualty Department of Cairns Base Hospital. Similarly the local pathology laboratories were contacted and asked about any requests for measles serology. These contacts quickly revealed that measles was first diagnosed in Cairns in early February and had become established over the following 4 weeks (Figure 1).

Figure 1. Cases of measles by week, Cairns

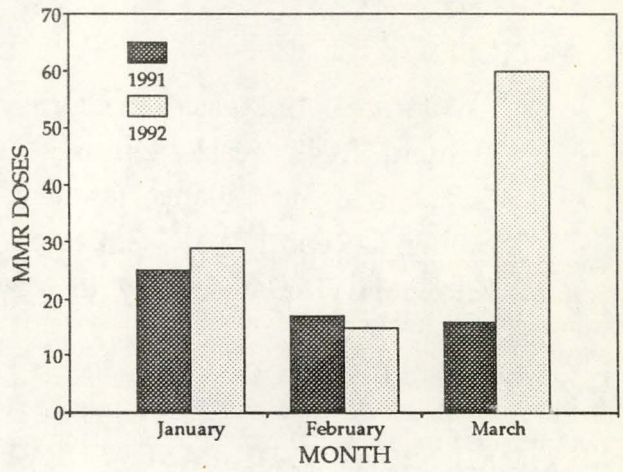


Further, several of the cases were enrolled in local childcare and pre-school facilities, and it was apparent that transmission of measles had occurred in some of the facilities. No measles control interventions, such as the exclusion of non-immunised contacts, had been implemented.

A brief circular was distributed to all the local general practitioners and community health centres; the circular emphasised the need for immediate notification of cases so that appropriate interventions could be implemented. Another circular was prepared for public distribution through community health centres and child care facilities.

By the end of the first week of March it was apparent that the measles epidemic would require a more intensive response. A press release was distributed and subsequently the local newspaper, radio and television stations ran stories about measles, emphasising the need for urgent immunisation of susceptible children. Examination of Cairns City Council clinic records showed a considerable increase in the number of doses of MMR vaccine administered by the clinic following the media activities (Figure 2), and local practitioners reported considerable demand for measles immunisation (Dr R Heazlewood, personal communication).

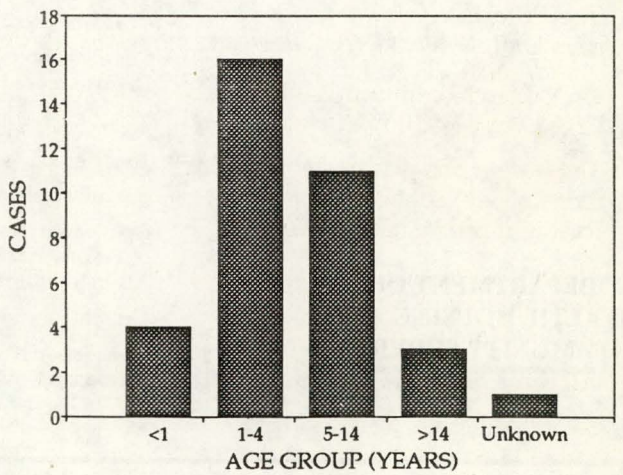
Figure 2. Doses of MMR vaccine administered by Cairn City Council clinic, by month, 1991 and 1992 (Source: Ms K English)



On 16 March two separate on-site immunisation clinics were held at two child care facilities in which new measles cases were enrolled. The clinics immunised 30 age-eligible children (Dr S Vlack, personal communication).

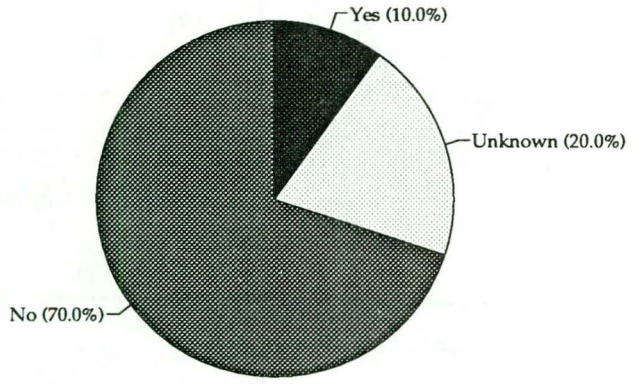
Analysis of the details of the cases revealed that most of the affected patients were either preschool aged children or primary school children (Figure 3).

Figure 3. Distribution of measles cases, Cairns, by age group



The majority of the cases over 12 months of age had not been previously immunised (Figure 4).

Figure 4. Immunisation status of measles cases over 12 months of age



The initial source of the epidemic remains uncertain. Fortunately there was no apparent spread of measles from Cairns to either Townsville (Dr I Shellshear, personal communication) or to remote communities in Cape York. However, two children who acquired measles in Cairns became symptomatic soon after arrival in two different towns in the Northern Territory (Dr M Patel, personal communication).

This small and localised measles outbreak has highlighted several important problems relevant to communicable disease control in north Queensland:

1. inadequate notification and surveillance of an important communicable disease,
2. lack of accepted outbreak control protocols, and
3. suboptimal immunisation levels in young children.

We are grateful to the Northern Territory Communicable Disease Centre for sharing their measles outbreak control protocol with us. That protocol is currently being modified to develop appropriate measles surveillance and control procedures for north Queensland. A survey of the immunisation status of young children upon enrolment to child care facilities is being planned.

CDI Editorial Comment

Ten per cent of the cases recorded in this outbreak had previously been vaccinated against measles. As vaccination coverage in a community inceases, so does the proportion of cases which occurs in persons who have been immunised, because the vaccines are less than 100% efficacious (detailed further in *CDI* 1991;15:208-209).

The live attenuated measles vaccine used in Australia is considered to have an efficacy of about 95%, so 10% of cases occuring in vaccinated individuals corresponds to a vaccine coverage of only about 70%, clearly insufficient to prevent outbreaks of measles, which is the most infectious of the vaccine preventable diseases in childhood. Indeed, it has been estimated that about 90-95% of children must be protected by immunisation to prevent transmission of measles.

It follows that, since the vaccine is only about 95% efficacious, about 95-100% of children must be immunised for outbreaks to be avoided.

Reference

1. Anderson RM and May RM. *Infectious Diseases of Humans Dynamics and Control*. Oxford:Oxford University Press, 1991.

TENNANT CREEK MEASLES OUTBREAK FEBRUARY - MARCH 1992

(Rosie Brennan, Communicable Disease Control Centre, Alice Springs; Gaye Gokel and Marion Maloney, Communicable Diseases Unit, Tennant Creek. Reproduced from the Northern Territory Communicable Diseases Bulletin, May 1992)

On 2 March, communicable diseases staff in Tennant Creek were notified of a measles outbreak in town.

The index case was an 11 year old student at Tennant Creek High School who had been to Cairns in the fortnight before his diagnosis.

Nineteen patients with measles presented to health practitioners in Tennant Creek between 14 February and 14 March. Of these, 15 had measles antibodies.

All cases fulfilled the clinical case definition[1].

Seventeen cases were adolescents (mean age 13 years; range 11.6 to 16.4 years) and one case was a 16 month old infant. Five patients were Aboriginal children.

Apart from the index case and two siblings who had been to Alice Springs, none of the cases had left Tennant Creek during the fortnight preceding the onset of illness.

Thirteen of the 19 cases had no personal or health service record of measles vaccination. Parents of one child claimed she had been vaccinated but the record was not sighted. Three cases were vaccinated in Tennant Creek in 1979 and two others were vaccinated shortly before their illness. The infant and a teenager who were both IgM positive, had measles-mumps-rubella vaccine (MMR) 19 and 3 days respectively before the onset of the rash.

The index case had blood taken on 14 February, but was not notified until 5 March. Immunisation of contacts was therefore delayed.

Reference

1. Centers for Disease Control. Case definitions for public health surveillance. *MMWR* 1990;39(RR-13):23.

The Northern Territory Communicable Diseases Bulletin Editorial Comment

Measles is a highly infectious disease of great public health importance. It is a difficult disease to diagnose clinically with absolute certainty, but control measures should begin on suspicion while awaiting serological confirmation. The delay in reporting the disease to the regional Northern Territory Centre for Disease Control and failure to institute control measures while awaiting serology results, resulted in 15 secondary cases and three tertiary cases in Tennant Creek. The index case in Tennant Creek had visited Cairns in early February. When the Tropical Centre for Disease Control in Cairns was notified of this patient, 35 other cases had been identified in the Cairns district (reported by Dr Jeffrey Hanna in *CDI* 16:119, and in this issue of *CDI*).

The IgM positive infant who received vaccination 19 days before the onset of symptoms may have had vaccine induced IgM and a coincident infection mimicking measles. The older child would have been incubating measles at the time of vaccination.

GONOCOCCAL SURVEILLANCE - AUSTRALIA, 1 JANUARY TO 31 MARCH 1992

(Contributed by the Australian Gonococcal Surveillance Programme, Co-ordinator, Dr J W Tapsall, The Prince of Wales Hospital, Sydney)

This report provides details of the 416 isolates of *Neisseria gonorrhoeae* examined by Australian Gonococcal Surveillance Programme (AGSP) participants in the first quarter of 1992, this being virtually the same number of strains examined both in the corresponding period of 1991 and in the December quarter of 1991.

The penicillin sensitivity of isolates from Brisbane, Sydney and Melbourne are shown in the Table. Currently these are the only centres with sufficient numbers of strains to analyse in terms of percentage.

Strains are categorised according to criteria revised 1 July 1991 (see *CDI* 1992;16:36) and are compared with data from the same period in 1991.

A number of trends have been noted in recent quarters, namely the increase in strains fully sensitive and relatively resistant by chromosomal mechanisms and a decline in the endemic transmission of penicilliase producing *N. gonorrhoeae* (PPNG). In this quarter the proportion of strains fully sensitive to penicillin again increased in Sydney and Melbourne, whereas the number of relatively resistant strains (chromosomally resistant *N. gonorrhoeae* - CMRNG) declined in overall numbers and isolates of this type were found only in Sydney and Melbourne.

The 57 PPNG strains were isolated in Sydney, Melbourne, Brisbane and Adelaide. In 21 patients, details on acquisition were not available, but in the remaining 36 cases, 5 were strains acquired locally and 31 overseas, confirming the decline in endemic transmission of PPNG.

Table. Penicillin sensitivity of isolates of *Neisseria gonorrhoeae*, 1 January to 31 March 1992

Centre	Percentage of Isolates[1]							
	Sensitive[2]		Less Sensitive[3]		Relatively Resistant[4]		PPNG[5]	
Brisbane	7.9	(17.4)	76.2	(60.9)	0	(7.2)	15.9	(14.5)
Sydney	33	(17.4)	40	(56)	10	(15.5)	17	(11.1)
Melbourne	36.8	(19.8)	36.8	(53)	5.3	(2.1)	21.1	(25)

1. Figures in parentheses represent data from the equivalent period in 1991. These differ from that previously shown for that period insofar as reclassification of categories occurred 1 July 1991.
2. Sensitive, Minimal Inhibitory Concentration ≤0.03 mg/L.
3. Less Sensitive, Minimal Inhibitory Concentration = 0.06 - 0.5 mg/L.
4. Relatively Resistant, Minimal Inhibitory Concentration ≥1.0 mg/L.
5. PPNG, penicillinase producing *Neisseria gonorrhoeae*.

REPORT FROM THE WHO COLLABORATING CENTRE FOR INFLUENZA, CSL

Influenza activity in the last northern winter was almost exclusively due to influenza A viruses. Influenza A (H3N2) strains predominated and were responsible for major outbreaks in Europe and the USA, and the latter reported significant associated excess mortality. Whilst there was some antigenic heterogeneity amongst the virus isolates most were closely related to the A/Beijing/353/89 vaccine strain and reacted well with antibodies induced by this strain.

Apart from outbreaks in Japan, influenza A (H1N1) viruses were isolated less frequently and generally later in the season than the H3N2 subtype. An antigenic variant, A/Texas/36/91 displaying slight antigenic drift was recognised and approximately 40% of influenza A(H1N1) isolates from Europe and the USA resembled this strain. Influenza B isolates were infrequent.

With early outbreaks of influenza in New Zealand and southern Australia, the WHO Influenza Centre has received an unusually large number of virus isolates for analysis early in the season. To the beginning of June, seventy-six isolates, all influenza A viruses, have been received from Australian laboratories, and this exceeds the total number for last winter. A further nineteen isolates have been made at the Centre from clinical specimens submitted from sentinel practices and health service clinics in the Melbourne metropolitan region.

Influenza activity in New Zealand has been largely due to influenza A (H1N1) and isolates analysed to date are antigenically close to the A/Singapore/6/86 and A/Victoria/36/88 strains included in vaccines over recent years.

The Australian outbreaks on the other hand are almost entirely due to influenza A (H3N2) and appear to be following the pattern seen in the last northern winter. There is, as expected, some antigenic heterogeneity amongst the virus isolates analysed to date, however, most are closely related to the A/Beijing/353/89 vaccine strain and react to high-titre with antibodies induced by this strain - typical haemagglutination-inhibition reactions of a panel of strains and some recent isolates are shown in the Table. Only two influenza A (H1N1) isolates have been received from Australia and these appear to show some minor antigenic drift from the A/Victoria/36/88 vaccine strain and most closely resemble the A/Texas/36/91 variant as did about 40% of influenza A (H1N1) isolates from the northern winter.

Table. Haemagglutination inhibition reactions, influenza A (H3N2) strains

	ANTISERUM				
STRAIN OR ISOLATE	A/England	A/Beijing	A/Shanghai/6	A/Shanghai/24	A/Washington
Reference Strain					
A/England/427/88	**640**	640	425	640	215
A/Beijing/353/89	240	**960**	480	240	480
A/Shanghai/6/90	215	640	**640**	320	320
A/Shanghai/24/90	480	240	240	**480**	160
A/Washington/15/91	55	160	40	80	**105**
Virus Isolate					
A/Fiji/1/92	60	240	60	80	160
A/Vic/12/92	320	640	640	640	640
A/Vic/19/92	320	640	320	320	640
A/Vic/24/92	480	960	480	480	480

KNOWN HIV-RELATED ENTRY RESTRICTIONS, BY COUNTRY, SITUATION AS AT 3 MARCH 1992

The United Kingdom's Foreign and Commonwealth office regularly issues an informal listing of all HIV/AIDS-related restrictions on international travel.

The list reproduced below summarises the information that was available to the Office up to 3 March 1992. While the list is as accurate as possible, it may not be comprehensive and should not be treated as a statement of the law in any country. Regulations in any one country are subject to alteration at short notice and individual immigration officials may be acting on instructions not known to the Office. In many countries the interpretation and implementation of official rules varies widely. Intending travellers are advised to check with the Embassy or High Commission of the country concerned. Diplomats are exempt from any requirement in all the countries listed.

Australia

Applicants for permanent residence are tested for HIV antibodies. An HIV positive result will be taken into consideration and may lead to the residency application being rejected.

Belgium

Foreign students applying for a Belgian Government scholarship are required to be tested for HIV antibodies by a Belgian doctor in their country of origin.

Belize

Foreign nationals entering Belize with the intention of becoming Belizean citizens must produce an HIV antibody test certificate issued not more than three months earlier.

Bolivia

Foreign nationals intending to stay in Bolivia for longer than 90 days are required to have HIV tests at the nearest Government sanitary unit within 48 hours of their arrival.

British Virgin Islands

Applicants for residence permits must produce, on arrival, a health certificate which includes a negative HIV antibody test result.

Brunei Durussalam

No formal testing requirement exists but those known to be HIV positive are likely to be refused entry.

Bulgaria

Foreign nationals staying in Bulgaria for longer than one month are required to be tested for HIV antibodies within 72 hours of their arrival.

Cayman Islands

Foreign nationals applying for work permits are required to submit HIV test certificates.

China

Foreign nationals applying for permanent residence or intending to stay or study in China for more than one year must produce an HIV antibody test certificate on arrival or undergo an HIV antibody test within 20 days of their arrival in China. Any test carried out abroad must be approved by the Chinese Embassy or Consulate.

Colombia

Applicants for long-term or permanent residence permits must provide proof of absence of communicable diseases, including absence of HIV infection. HIV antibody test certificates issued abroad are accepted.

Cuba

Foreign students, foreign workers and long term foreign residents are screened for HIV antibodies.

Cyprus

Foreign nationals seeking work permits to work in night-clubs or as cabaret artists are screened for HIV antibodies by Cypriot authorities.

Cyprus (North)

All applicants for long term residence permits are screened for HIV antibodies. There are six-monthly checks of individuals in high-risk categories.

Czechoslovakia

Foreign students and foreign resident workers are screened for HIV antibodies on arrival. This requirement may soon be abolished.

Egypt

Foreign defence contractors working at Egyptian military establishment must carry an HIV antibody test certificate. All foreigners intending to stay for more than one month must undergo an HIV antibody test. Certificates issued abroad are not accepted.

Finland

Compulsory screening for HIV antibodies is limited to foreign students sponsored by FINNIDA.

Germany

(a) Foreign Scholarship Holders and trainees from developing countries who are to participate in a study program financed by the Federal Ministry of Economic Co-operation for more than 3 months are liable to undergo an HIV antibody test as part of the routine medical examination. HIV positivity is grounds for refusal of a place.

(b) (Bavaria only) Foreign nationals applying for resident permits, or those staying as tourists longer than four months who need their visas extended, must

undergo an HIV antibody test. The following are exempt from these requirements: all EC nationals, nationals of Andorra, Finland, Iceland, Liechtenstein, Malta, Monaco, Norway, Austria, San Marino, Sweden, Switzerland, Vatican City.

Greece

Non-EC foreign students studying in Greece are required to take an HIV antibody test.

Hungary

Students from sub-Saharan Africa receiving government scholarships are required to take an HIV test.

India

All foreign nationals who intend to stay in India for more than one year are subject to health tests including an HIV test, apart from:

a) those working in diplomatic missions

b) journalists accredited to the Indian Press Information bureau

c) residents of India who have not travelled abroad

d) those under 18 or over 70 years of age

e) nuns and priests

f) those with an HIV-free certificate issued, in the previous month, by a WHO-recognised laboratory.

Indonesia

Indonesia has no screening policy, but foreign nationals found to be HIV positive will not be given extensions to their initial leave to remain in the country.

Iraq

An HIV antibody test and syphilis test are compulsory for all overseas visitors except for the following:

a) Persons visiting Iraq for not more than five days;

b) Persons invited officially by State Departments, provided their stay does not exceed 15 days;

c) Children under 12 with a written confirmation fromtheir parents that they are not haemophiliacs and/or have not undergone a blood transfusion;

d) Persons over 65;

e) Diplomats, members of international organisations, holders of diplomatic and service passports, and their spouses and families.

Not more than 3 months may have elapsed between the date of issue of a certificate of HIV negativity and the date of entry into Iraq. Alternatively, visitors can present themselves for an HIV test within 5 days of arrival in Iraq for which a fee of ID 100 (approx $400) will be charged. Failure to comply with these regulations can result in imprisonment.

Japan

No formal testing requirement exists, but persons discovered to have HIV who are 'deemed likely to infect others by means of promiscuous behaviour' may be refused entry.

Jordan

Foreigners staying in Jordan for more than a month and therefore requiring a residence permit are required to undergo an HIV antibody test.

Korea (South)

Persons working in the leisure or entertainment field (including athletes) who will be staying longer than 90 days must produce an HIV antibody certificate obtained in their country or origin or undergo testing in-country. Persons accompanied by their spouses are exempt.

Kuwait

Foreign nationals applying for work permits are screened for HIV antibodies on arrival.

Libya

Foreign workers and long term visitors must produce an HIV antibody test certificate.

Malaysia

HIV positivity is not in itself grounds for refusing entry to a foreign national and there is no compulsory screening requirement for visitors. However, the Immigration Department has the authority to advise a foreign national to leave the country if it considers that person likely to spread HIV infection. Anyone who knows or has reason to believe they are HIV positive who acts in a manner likely to spread the disease can be prosecuted and imprisoned.

Mexico

Foreign nationals intending to reside permanently in Mexico must present to the immigration services a health certificate showing a negative HIV antibody test result.

Mongolia

Foreign students are required to undergo an HIV antibody test on arrival, repeated several months later. Students will be allowed to supply their own needles for the test.

Montserrat

Foreign nationals applying for or renewing work or residence permits must produce an HIV antibody test certificate.

Oman

Foreign nationals intending to take up employment in the private sector are required to take HIV tests on arrival. This requirement will, in the future, be extended to those working in the public sector and non-employed family members. Further testing will be required every two years on renewal of work permits.

Pakistan

Officially, foreign nationals intending to stay in Pakistan for more than a year must produce an HIV antibody test certificate. In practice this requirement tends to be applied only to those long-term visitors from countries with a high incidence of HIV/AIDS.

Papua New Guinea

Foreign nationals applying for work permits and long-stay visas must undergo a health check, including an HIV antibody test.

Philippines

Foreign nationals entering or residing in the Philippines as permanent residents or immigrants must produce an HIV antibody test certificate.

Poland

Foreign students intending to study in Poland for 'more than a few weeks' are tested for HIV antibodies on arrival.

Qatar

Foreign nationals applying for work permits and their foreign-born dependents must undergo an HIV antibody test.

St Kitts and Nevis

Foreign nationals seeking permanent residence and those applying for work permits may be asked to undertake an HIV test.

Saudi Arabia

Foreign nationals applying for a work or residence permit must produce an HIV antibody test certificate.

Singapore

Foreign nationals found to be HIV positive or to have AIDS are repatriated. There is a compulsory testing requirement for foreign maids wishing to work in Singapore.

Soviet Union

Foreign nationals aged over 15 who intend to stay in the USSR for three months or more must produce an HIV antibody test certificate or undergo a test in-country. HIV positivity is grounds for expulsion. Those foreigners already in the Soviet Union who leave the country for a month and intend to return for periods of over three months must produce a new certificate not more than one month old.

Sri Lanka

Foreign nationals suspected of being HIV positive may be refused entry under general immigration regulations.

Syria

Both foreign nationals applying for work permits and foreign students must undergo an HIV antibody test at one of three specified centres in Syria.

Taiwan

Foreign nationals staying for more than three months are required to take an HIV antibody test. If they refuse or the test is positive, they may be forced to leave the country.

Thailand

Foreign nationals known to be HIV positive or to have AIDS are refused entry. Foreign nationals already in the country who are subsequently found through windfall information to be HIV positive or to have AIDS may be deported. The Thai authorities have now decided to repeal this legislation, and it is no longer being enforced.

Trinidad and Tobago

All foreign nationals applying for residence or to stay for more than one year need to undergo a medical examination. If it becomes known during the course of examination that a person is HIV positive or has AIDS, he or she would be refused permission to stay under the existing immigration provisions for those with a communicable disease.

Turks and Caicos Islands

All foreign nationals applying for work and residence permits are required to submit to a medical examination which must be done in the TCI. The medical includes a test for HIV antibodies. Medical certificates issued in other countries are not acceptable.

United Arab Emirates

Foreign nationals applying for, or renewing, work or residence permits must undergo an HIV antibody test. If the test result is positive, entry is refused.

United States of America

Applicants for immigrant visas, refugees and aliens already in the United States seeking permanent residence status who are found, in the qualifying medical examination, to have AIDS or to be HIV positive will not be granted permanent residence. Although there is no compulsory screening of applicants for non-immigrant visas, those discovered to be HIV positive will be refused admission. Persons planning to attend conferences, receive medical treatment, visit relatives or visit on business may apply for a waiver, allowing them to enter the United States. Tourism is not counted as grounds for the granting of a waiver, except in certain circumstances (for example children, haemophiliacs). The United States Administration has been reviewing this area of their immigration procedures.

OVERSEAS BRIEFS

In the last two weeks, the following information has been supplied by the World Health Organization.

Cholera Update

In Brazil, Alagoas State and Ceara State have been declared infected.In Mozambique, the Manjacaze and Macia Districts in Gaza Province, the Marracuene District in Maputo Province, Nhamatanda, Buzi and Dondo Districts in Sofala Province, and the Mocuba District in Zambezia Province have been declared cholera infected. The Namaacha District in Maputo Province, the Chiure District and Pemba City in Cabo Delgado Province and the Mopeia District in Zambezia Province have been removed from the infected areas list.

Cases for May have been reported from Angola, Brazil, El Salvador, Guatemala, Honduras, Kenya, Nicaragua, Panama and Venezuela.

Influenza Update

In New Zealand, localised outbreaks of influenza A (H1N1) started at the end of March and have now spread to most parts of the country. Cases have occurred in all age groups.

In Papua New Guinea, influenza A has been diagnosed by virus antigen detection in children since February.

COMMUNICABLE DISEASES SURVEILLANCE

Laboratory Reporting Schemes

There were 1557 reports received in the *CDI* 'Viruses' Reporting Scheme this fortnight (Tables 6,7 and 8).

- There were 87 reports of **influenza**. Eighty-five of these were **influenza A**, 29 of these were further identified as H3N2, and 19 of these were reported as A/Biejing/353/89-like.

  Five reports of influenza A (H3N2) were in persons over the age of 65 years, as were 10 of the reports for untyped influenza A.

  Another report was of a 22 year old male patient who died on the same day that his nasopharyngeal specimen was collected. The patient, who had influenza A diagnosed by antigen detection, had also had severe cystic fibrosis. A 2 year old male patient, who had influenza A isolated from a throat specimen, had atypical febrile convulsions as the reported syndrome.

  The number of influenza A (H3N2)/untyped reports received so far this year is much higher than is usual, and even higher than in 1989, the last year in which there were large numbers of these reports (Figure 1).

  The most reports have been from laboratories in South Australia (112 reports) and Victoria (110 reports), and there have been 42 from New South Wales, 26 from Western Australia, 6 from Queensland and 4 from the ACT. Report numbers began to increase in South Australia in March, and in Victoria and New South Wales in April (Figures 2 and 3).

Figure 1. Influenza A and influenza A (H3N2) laboratory reports, 1989 and 1992, by month of specimen collection

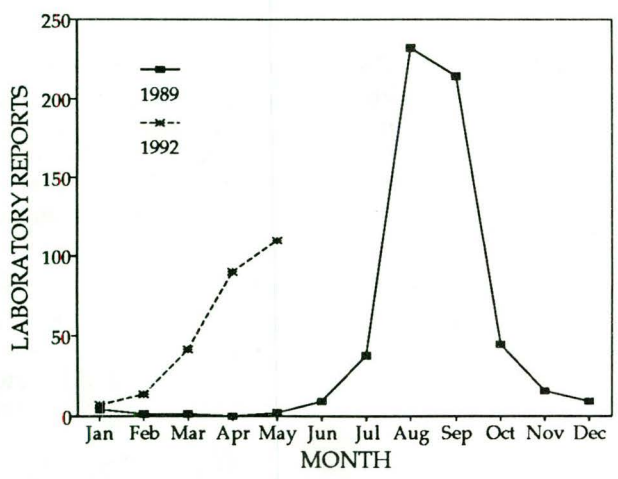


Figure 2. Influenza A and influenza A (H3N2) laboratory reports, 1992, South Australia, New South Wales and Queensland, by month of specimen collection

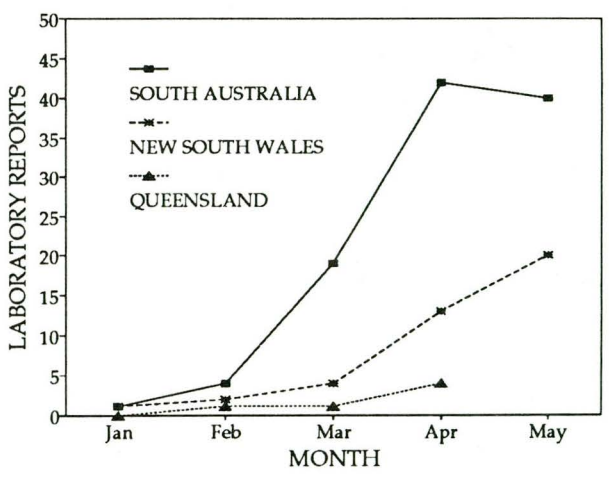
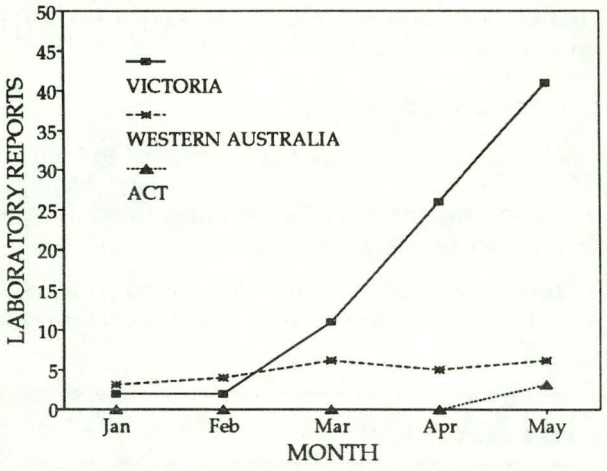
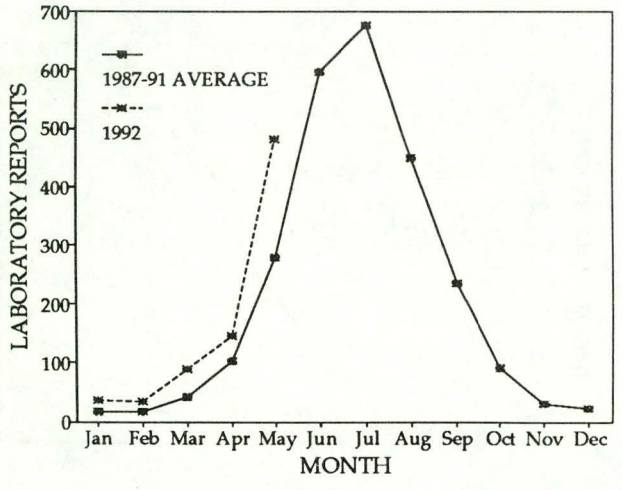


Figure 3. Influenza A and influenza A (H3N2) laboratory reports, 1992, Victoria, Western Australia and the ACT, by month of specimen collection



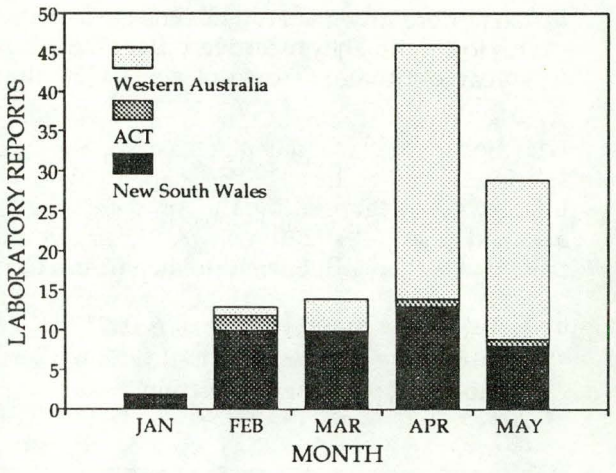
- The first report of **influenza A (H1N1)** for the season was also received this fortnight. The patient was a 41 year old female. The virus was isolated by a Victorian laboratory and was A/Victoria/36/88-like.
- One report of **influenza B** was also received this fortnight, bringing the total for the year so far to 27. Influenza B reports have not begun to increase until June or July in influenza B epidemic years in Australia.
- **Respiratory syncytial virus** was reported for 443 patients this fortnight, bringing the total for the year to 1013, more than has been usual by this time of year in recent years (Figure 4). One patient, a 2 year old female, was reported to have acquired the infection nosocomially.

Figure 4. Respiratory syncytial virus reports, 1992 and 1987-91 average, by month of specimen collection



- The seasonal increase in reports of **rotavirus** infection has also begun. There were 58 reports this fortnight, making a total of 297 so far this year, about the average for recent years.
- **Ross River virus** infection is still being reported, mainly from Queensland and Western Australian laboratories. The specimen collection date for most of the 55 reports this fortnight was May, and they were from the Rockhampton area (24 reports), Western Australia 28 (Carnarvon, Geraldton, Halls Creek, Hammersley, Kalgoorlie, Mandurah, Metropolitan Perth, Newman, Three Springs, Waggrakine), and there was one from each of Nhulunbuy, Northern Territory, New South Wales and South Australia.
- Reports of **echovirus type 6** and **echovirus type 9** were again received at a greater rate than usual this fortnight. There were 26 reports of type 9, and 24 of these had meningitis as the reported syndrome. Most were from Western Australia (22), and there were 3 from New South Wales and one from the ACT. Most of the 104 reports of this virus with 1992 specimen collection dates have been from Western Australia, with the remainder from New South Wales and the ACT (Figure 5).

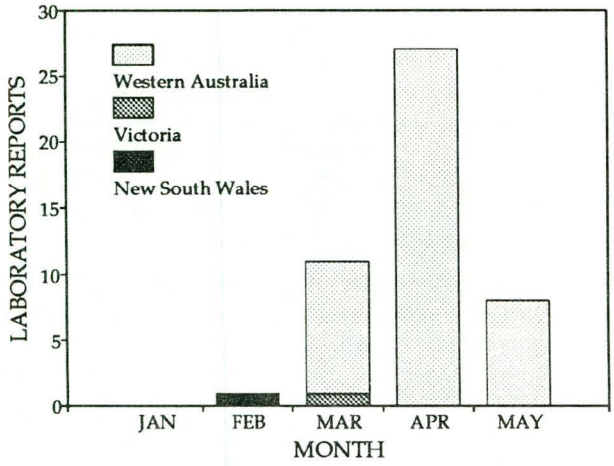
Figure 5. Echovirus type 9 laboratory reports, 1992, by month of specimen collection and State or Territory of reporting laboratory



- Meningitis was the reported syndrome for the 7 reports of **echovirus type 6** this fortnight. All of the cases were from Western Australia. Forty-five of the 47 reports of this virus this year have been from Western Australia, and there has been 1 case reported from each of New South Wales and Victoria (Figure 6).

Correction: in the last issue of *CDI*, the echovirus type 6 and echovirus type 9 Figures were inadvertently transposed. Figure 2 (nearer the top of page 258) was for echovirus type 6 and Figure 3 (at the bottom of the page) was for echovirus type 9.

Figure 6. Echovirus type 6 laboratory reports, 1992, by month of specimen collection and State or Territory of reporting laboratory



- A case of **echovirus type 7** infection was reported in a 2 month old female with meningitis. It was reported by a Victorian laboratory and is the first report of this rare virus since August 1991.
- **Herpes simplex virus** reports this fortnight included a type 2, isolated from post mortem lung and liver tissue of a 1 month old boy. The boy had presented with pneumonitis, hepatitis and encephalitis. His mother had received no antenatal care, presenting for the first time when in labour.
- There were 72 reports of **cytomegalovirus** infection this fortnight. They included 1 case of meningitis (a 1 year old male), 1 case of acute Guillain-Barré Syndrome, 2 cases in pregnant women, 1 case in a newborn male who had been born at 25 weeks gestation with splenomegaly, and 1 case of lower respiratory tract disease associated with Wagener's Granulomatosis (virus isolated from lung tissue).
- **Hepatitis C** was reported for 84 patients. One was a 1 month old male whose mother was hepatitis C positive. Others were a 16 year old HIV positive haemophiliac, a 48 year old female with a history of multiple blood transfusions in the recent past, a 20 year old male with Von Willebrand's Disease, 25 patients with a history of injecting drug use, and 2 patients with a history of alcohol abuse.
- There were 8 reports of **Q fever**. Seven were in adults in the age range 24 to 44 years. The other was in a 6 month old boy who had lower respiratory tract disease and general malaise; the organism was isolated from a nasopharyngeal specimen for this patient.
- There were 2 reports of **ornithosis**. For one patient, a 36 year old male with lower respiratory tract infection, the report was accompanied by the comment 'history of parrot breeding'
- One report of infection with ***Treponema pallidum*** was received. Such reports of serological diagnoses of syphilis are now included in the 'Viruses' scheme, and appear in Tables 6 and 7.

Correction - Annual Report

A correction is required for one of the tables published in the *Annual Report of the CDI 'Viruses' Reporting Scheme, 1991, CDI* 1991;16:206-221. In Table 2, page 209, the 4 reports of Murray Valley encephalitis virus in the column for Victoria should have been in the column for Western Australia.

LabVISE - Laboratory Database of Virology and Serology

This fortnight we welcome Liverpool Hospital, South Western Sydney Area Health Service to the *CDI* 'Viruses' laboratory reporting scheme. Liverpool Hospital, along with the Institute of Medical and Veterinary Science in Adelaide, and Royal Hobart Hospital, are now reporting identifications of viral infections and other related serological results to *CDI* using LabVISE, a new computer based reporting system. The system is now supplementing the current system of reporting viruses on paper forms, and it is hoped that it will eventually replace the paper system and therefore make it easier for both the contributing laboratories and *CDI* to handle the data.

LabVISE has been set up in parallel with LabDOSS, the computerised reporting scheme for bacterial isolates from sterile sites. It is similar in structure to LabDOSS, and, as LabDOSS takes over the reporting of sterile sites isolates from the 'Pathogens' reporting scheme, LabVISE will take over the reporting of infections caused by agents such as *Toxoplasma gondii, Echinococcus granulosus, Legionella* species, and other infections diagnosed in virology and serology laboratories.

Data collected in the LabVISE system are almost the same as those currently collected in the 'Viruses' scheme:

1. Clerical data: laboratory patient identification, the first two letters of the patient's surname and the first two letters of the patient's first name (to allow for checking for duplicate reports), date of specimen collection, sex, date of birth or age, and patient location information (postcode).
2. Clinical data: the diagnosis attributed to the organism, for example encephalitis, lower respiratory tract disease or gastrointestinal disease, risk factors such as an immunocompromised state, pregnancy, or overseas travel, and whether or not the patient died as a result of the infection.
3. Microbiological data: source specimen, method of diagnosis (isolation, antigen detection, antibody detection) and an identification of the organism which is as full as the laboratory has determined.

The LabVISE program has been written in EpiInfo, a program which was developed at the Centers for Disease Control in Atlanta, USA. It combines word processing, database management, statistical analysis

and graphics into a package which can be used by those with minimal experience with computers. The EpiInfo software, LabVISE programs (and LabDOSS programs, if required), EpiInfo manual and LabVISE manual are all supplied free of charge to both new laboratories that may wish to join the scheme, and current contributing laboratories which would like to convert from reporting on paper forms to reporting on floppy disk. (An IBM compatible computer is required.)

An important feature of the system is that, with monor modifications to the program, LabVISE can be tailored to the individual needs of the laboratory whilst retaining the ability to generate reports for *CDI*. Laboratories can record data other than those required for *CDI* reports, for example, full names and addresses of patients, referring practitioners, and details of hospitalisation. They can then use the programs to store and analyse both the data that are sent to *CDI* and their supplementary data.

Enquiries from new laboratories who may want to join the LabVISE scheme and from current laboratories who may want to convert to computer based reporting are welcome. The contacts are David Evans, phone (06) 289 7155 and Jenny Hargreaves, phone (06) 289 7808.

Australian Sentinel Practice Research Network

The Australian Sentinel Practice Research Network collected data from 6664 patient encounters in Week 24 and 6040 patient encounters in Week 25 (Table 1). Influenza and gastroenteritis were again the most commonly reported conditions.

The rate of influenza reports has increased steadily through the period March to June (Figure 7), and has been reported at a rate of 13 per 1000 encounters or more since mid-May. This increase is in very good agreement with laboratory reports of influenza A (H3N2)/untyped (Figure 1).

Figure 7. ASPREN reports of influenza, 1992, by week

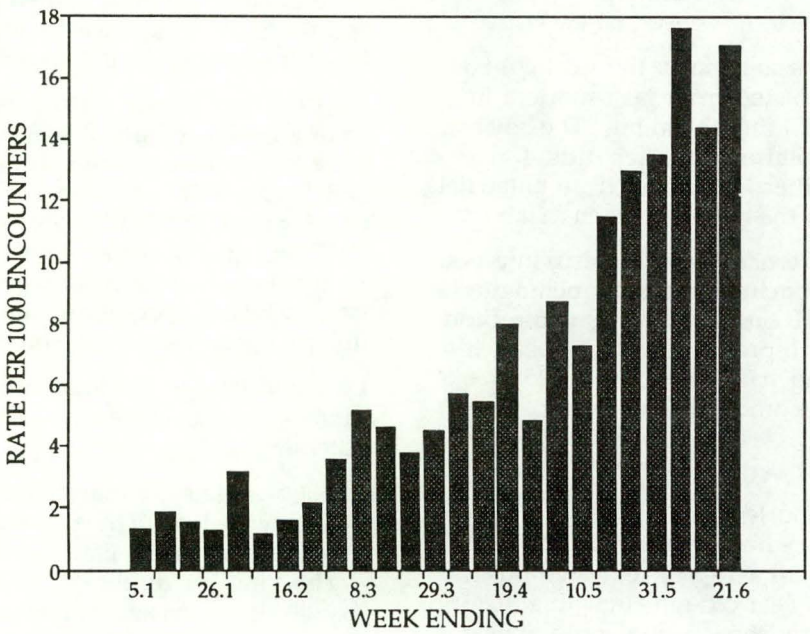


Table 1. Australian Sentinel Practice Research Network, Weeks 24 and 25, 1992

Condition	Week 24, to 14 June 1992		Week 25, to 21 June 1992	
	Reports	Rate per 1000 encounters	Reports	Rate per 1000 encounters
Influenza	96	14.41	103	17.05
Measles	0	0	0	0
Mumps	1	0.15	0	0
Rubella	1	0.15	1	0.17
Pertussis	0	0	0	0
Genital herpes	3	0.45	4	0.66
Gastroenteritis	50	7.50	59	9.77

Victorian Influenza Surveillance System

Included in this issue of *CDI* are results from the first 3 fortnights for the Victorian Influenza Surveillance System (Table 2).

This system has been set up by the Infectious Diseases Unit of the Health Department, Victoria, and includes surveillance data supplied by sentinel general practices, diagnostic laboratories, hospitals, schools and industry. Total deaths (which usually increase during influenza epidemics) are also being monitored.

The rates of influenza reporting from the sentinel practices, hospitals and laboratories have risen over the period of surveillance so far.

(Raina MacIntyre, Health Department Victoria)

Cholera Case in New South Wales

A case of cholera has been reported from New South Wales. The patient was a 46 year old female resident of northern Sydney who had been visiting India.

(Michael Levy, New South Wales Health)

National Notifiable Diseases Reports, 31 May to 13 June 1992

A total of 1284 notifications were reported for the reporting fortnight 31 May to 13 June 1992 (Figure 8, Tables 3, 4 and 5) and were available for analysis. Notifications from New South Wales were not available.

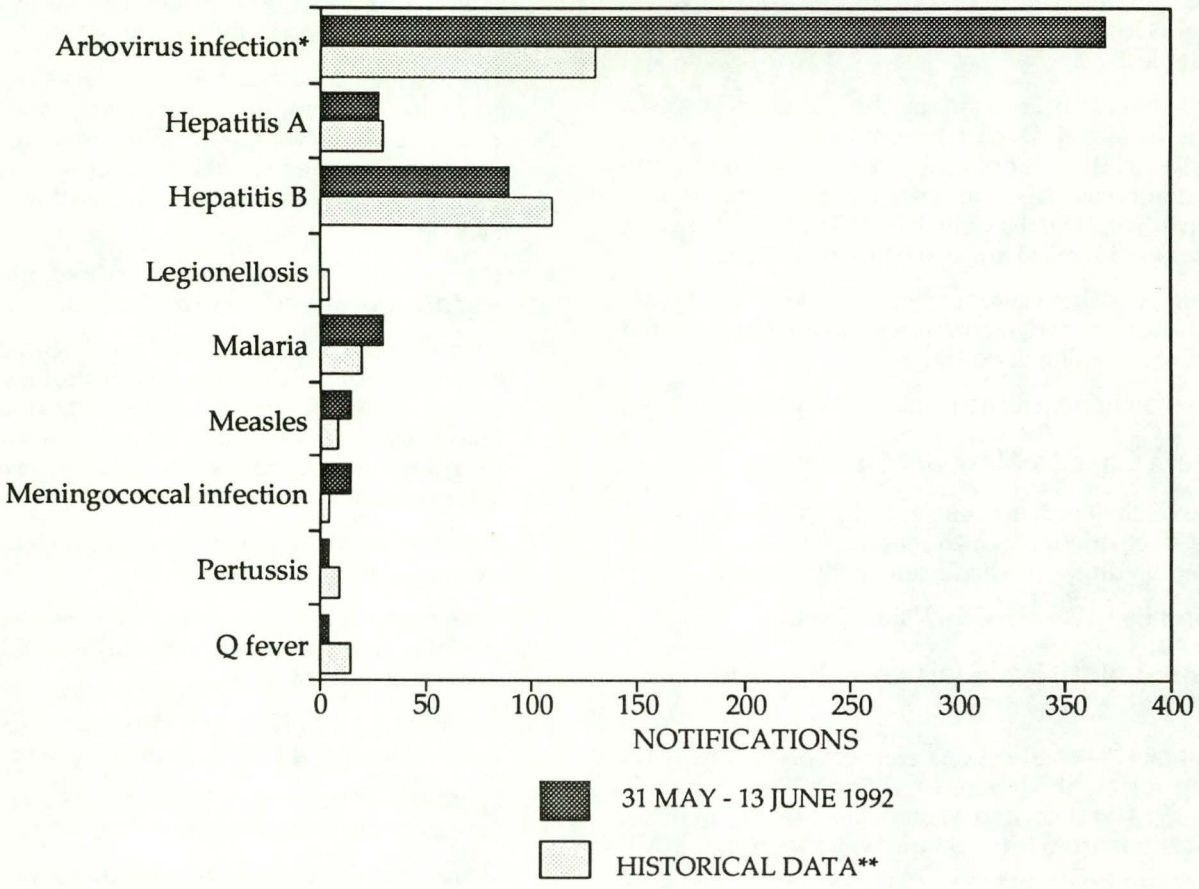
- There were 36 notifications of **dengue**, 14 males and 22 females. All ages appeared affected. Notifications were from Townsville (92%), Brisbane and Cairns.
- **Ross River virus** infections continue to be notified, with 309 notifications mainly from Queensland (88%). The predominant age group was 25 to 55 years, sex was reported as male in 44% and female in 56%. Just under 50% of notifications were from Townsville and surrounding areas.
- There were 12 cases of ***Haemophilus influenzae*** type b infection notified. There were 6 males and 6 females and all were under 5 years of age. Three were 1 year of age or less. Two cases were reported from adjacent postcode areas within four days of each other.
- There were 9 notifications of **measles**. Eight were 1 year of age or older; 6 were male and 3 were female.
- There were 12 notifications of **meningococcal** disease. There were 8 males and 4 females, and 6 were 2 years old or younger. Two cases occurred within 4 days of each other in adjacent postcode areas, and a further 2 cases occurred 14 and 25 days after the first case in a nearby postcode area.
- Six notifications of **pertussis** were received. Three were aged less than 1 year.
- Four notifications of **rubella** were received. One was of unknown sex and one was a female in the age group 15 to 44 years.
- One notification of **hydatid disease** was received, in a woman in the 45 to 49 year age group.
- There was one report of **legionellosis**, in a male in the age group 45 to 49 years.
- There were 2 notifications of **leptospirosis**. Both were for males in the age group 30 to 49 years.
- Two reports of **listeriosis** were received. Both were for males in the age group 35 to 44 years.
- There was a single case of **typhoid** notified, from the Northern Territory.

Table 2. Victorian Influenza Surveillance System, Fortnights 1, 2 and 3, 1992 (4 May to 12 June 1992)

	Fortnight 1 4 May - 15 May	Fortnight 2 18 May - 29 May	Fortnight 3 1 June -12 June
General Practices (34) Influenza cases per 100 patients seen	1.5	2.1	2.6
Laboratories (2) Influenza cases (per 100 specimens)	12 (-)	21 (9)	58 (19)
Hospitals (3) Admissions with influenza and/or pneumonia	22[1]	41	48[2]
Schools (30) Total absenteeism, Tuesday, per 100 persons	10.0	-[3]	23.0
Industry (2) Total absenteeism, per 100 employees	6.2	3.4	5.8
Deaths Total per 10,000 population	3.3	3.1	2.6

1. Data missing from one hospital.
2. One per 100 admissions.
3. School data received on alternate fortnights only.

Figure 8. Selected National Notifiable Diseases Reports, 31 May to 13 June 1992, and historical data**



*Includes Ross River virus and Dengue
**The Historical data are the averages of the number of notifications in 6 previous 2-week reporting periods: the corresponding periods of the last 2 years and the periods immediately preceding and following those.

Table 3. Diseases preventable by vaccines recommended by the NHMRC for routine childhood immunisation for the reporting period 31 May to 13 June 1992

DISEASES	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	TOTALS FOR AUSTRALIA[1] This Period 1992	This Period 1991	Year to Date 1992	Year to Date 1991
Diphtheria	0		0	0	0	0	0	0	0	0	9	3
Measles	0		0	5	0	0	4	0	9	2	383	568
Mumps	0		NN	NN	NN	NN	0	NN	0	NN	0	NN
Pertussis	0		0	2	2	0	1	1	6	18	190	192
Poliomyelitis	0		0	0	0	0	0	0	0	0	0	0
Rubella[2]	0		0	2	0	0	2	0	4	9	181	177
Tetanus	0		0	NN	0	0	0	0	0	0	5	5

1. Totals comprise data from all States and Territories. Cumulative figures are subject to retrospective revision, so there may be discrepancies between the number of new notifications and the increment in the cumulative figure from the previous period.

2. NT, Tas, WA: CRS only; ACT, NSW, Qld: rubella only; SA, Vic: rubella and CRS

NN Not Notifiable.

Table 4. Other Notifiable Diseases[1], for the reporting period 31 May to 13 June 1992

DISEASES	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	TOTALS FOR AUSTRALIA[2]			
									This Period 1992	This Period 1991	Year to Date 1992	Year to Date 1991
Arbovirus infection (NEC)[3]	0		NN	22	1	0	2	0	25	6	218	160
Ross River virus infection	0	-	3	269	0	NN	2	35	309	99	4461	2989
Dengue	0	-	0	36	-	NN	0	NN	36	0	52	40
Campylobacteriosis[4]	1	-	5	90	68	16	14	16	210	276	3586	3385
Chlamydial infection (NEC)[5]	4	NN	7	81	0	9	23	0	124	358	2711	1830
Donovanosis	0	NN	0	0	NN	NN	0	0	0	3	30	27
Gonococcal infection[6]	0		7	11	0	0	3	32	55	134	1241	1079
Haemophilus influenzae type b[7]	0		NN	1	5	0	6	NN	12	23	191	194
Hepatitis A	0		1	16	0	0	4	0	21	54	854	491
Hepatitis B	2		1	44	1	2	34	4	88	131	2594	1445
Hepatitis C	1		NN	77	NN	2	56	NN	136	68	3369	1099
Hepatitis (NEC)	0		0	1	0	0	0	NN	1	4	30	169
HIV infection[8]	4		0	0	1	0	0	3	8	3	119	13
Legionellosis	0		0	0	1	0	0	0	1	10	75	54
Leptospirosis	0		0	2	0	0	0	0	2	9	44	73
Listeriosis	0		NN	2	NN	0	0	0	2	0	20	16
Malaria	1		2	9	0	1	4	1	18	27	321	373
Meningococcal infection	0		0	2	1	0	9	0	12	4	82	99
Ornithosis	0	NN	0	0	2	0	0	1	3	8	43	41
Q fever	0		0	9	0	0	0	0	9	22	193	325
Salmonellosis (NEC)	2		9	54	12	5	13	14	109	167	2644	3036
Shigellosis[4]	0	-	4	0	3	0	2	1	10	38	279	475
Syphilis	0		8	18	0	0	0	12	38	71	951	919
Tuberculosis	0		1	6	1	0	0	0	8	13	281	190
Typhoid[9]	0		1	0	0	0	0	0	1	1	25	37
Yersiniosis[4]	0	-	0	22	6	0	0	0	28	23	338	294

1. For rarely notified diseases, see Table 5.
2. Totals comprise data from all States and Territories. Cumulative figures are subject to retrospective revision so there may be discrepancies between the number of notifications and the increment in the cumulative figure from the previous period.
3. NSW and SA: includes Ross River virus and dengue.
4. NSW: only as 'foodborne disease' or 'gastroenteritis in an institution'.
5. ACT: trachoma only.
6. NT, Qld, SA and Vic: includes gonococcal neonatal ophthalmia.
7. SA: only as 'bacterial meningitis'; meningococcal infection is separately notified; Tas: only as 'non-meningococcal meningitis'; Vic: eppiglottitis and meningitis only.
8. More complete data on new diagnoses of HIV infections are presented in the monthly *Australian HIV Surveillance Report*. ACT: AIDS only.
9. NSW and Vic: includes paratyphoid.

NN Not Notifiable.

NEC Not Elswhere Classified.

\- Elsewhere Classified.

Table 5. Rarely Notified Diseases[1], for the reporting period 31 May to 13 June 1992

DISEASES	Total this period	Reporting States or Territories	Total for 1992 to Date
Botulism			0
Brucellosis			5
Cholera			1
Chancroid			5
Hydatid infection	1	Vic	18
Leprosy			6
Lymphogranuloma venereum			1
Plague			0
Rabies			0
Yellow fever			0
Other viral haemorrhagic fevers			0

1. Fewer than 50 cases of each of these diseases were notified each year during the period 1986 to 1991.

Table 6. Laboratory reports by State or Territory of reporting laboratory for the reporting period 3 June to 16 June 1992, historical data[1], and total reports for the year

	STATE OR TERRITORY OF REPORTING LABORATORY							Total this fortnight	Historical data [1]	Total reported this year
MEASLES, MUMPS, RUBELLA	ACT	NSW	Qld	SA	Tas	Vic	WA			
Measles virus						1		1	7.2	78
Rubella virus						1		1	7.5	92
HEPATITIS VIRUSES										
Hepatitis A virus		1	1	1		2		5	14.7	158
Hepatitis B virus	2	49	28	1		13	10	103	109.7	1,055
Hepatitis C virus	21		4	36	1		22	84	19.0	959
Hepatitis D virus			3					3	2.8	21
ARBOVIRUSES										
Ross River virus		1	24	1			29	55	35.7	957
Barmah Forest virus							3	3	.8	125
Dengue not typed						3	2	5	1.5	26
ADENOVIRUSES										
Adenovirus type 1						1		1	4.2	44
Adenovirus type 2		1				1		2	2.8	56
Adenovirus type 4						1		1	1.2	5
Adenovirus type 19						1		1	.0	4
Adenovirus not typed/pending		13	9	7		4	5	38	37.3	439
HERPES VIRUSES										
Herpes simplex virus type 1		7	11	9	1	21	23	72	126.3	1,725
Herpes simplex virus type 2	1	22	7	11	1	27	45	114	180.2	2,038
Herpes simplex not typed/pending	19	17	2			1	3	42	31.2	419
Cytomegalovirus	1	10	24	2		25	10	72	79.2	970
Varicella-zoster virus	1	1	1			5	7	15	20.5	314
Epstein-Barr virus	1	3	32	9		8	5	58	40.5	773
Herpes virus group - not typed						1	1	2	6.0	32
OTHER DNA VIRUSES										
Papovavirus group		1						1	.2	11
Parvovirus						3		3	.0	66
PICORNA VIRUS FAMILY										
Coxsackievirus B1						1		1	.2	7
Echovirus type 6							7	7	.7	49
Echovirus type 7						1		1	.3	1
Echovirus type 9	1	3					22	26	.3	106
Echovirus type 11						1		1	2.0	6
Echovirus type 17		1						1	.3	35
Echovirus type 21						1	1	2	.0	4
Poliovirus type 1 (uncharacterised)		3						3	2.7	26
Poliovirus type 2 (uncharacterised)		3						3	1.8	23
Poliovirus not typed/pending		2						2	3.3	33
Rhinovirus (all types)		3	9	2		14	3	31	28.0	323
Enterovirus not typed/pending		11	15			3	11	40	38.8	460
ORTHO/PARAMYXOVIRUSES										
Influenza A virus	4	6		13		30	3	56	1.5	256
Influenza A virus H1N1						1		1	.2	1
Influenza A virus H3N2		3				26		29	.0	57
Influenza B virus				1				1	2.8	50

Table 6. Laboratory reports by State or Territory of reporting laboratory for the reporting period 3 June to 16 June 1992, historical data[1], and total reports for the year, continued

	STATE OR TERRITORY OF REPORTING LABORATORY							Total this fortnight	Historical data [1]	Total reported this year
	ACT	NSW	Qld	SA	Tas	Vic	WA			
Parainfluenza virus type 1		2	1	2		5	2	12	15.2	226
Parainfluenza virus type 2						4	1	5	10.2	44
Parainfluenza virus type 3	1	2	1	1		5	1	11	15.2	230
Parainfluenza virus typing pending						8	2	10	2.8	63
Respiratory syncytial virus	5	141	117	7		95	78	443	168.0	1,085
OTHER RNA VIRUSES										
HIV-1							4	4	2.2	15
Rotavirus		13	16		1	13	15	58	66.7	501
Calici virus		3						3	.7	12
Coronavirus		4						4	1.3	16
Small virus (like) particle						1		1	2.5	28
OTHER										
Chlamydia trachomatis not typed	8	11	7	14		6	26	72	98.8	1,330
Chlamydia pneumoniae				2		1		3	.0	5
Chlamydia psittaci						2		2	4.3	62
Mycoplasma pneumoniae	3	14	2			10		29	11.0	343
Coxiella burnetti (Q fever)		3	1			4		8	10.7	121
Rickettsia australis			3					3	.0	7
Treponema pallidum			1					1	.0	1
Toxoplasma gondii			1					1	.0	3
TOTAL	68	354	320	119	4	351	342	1,557	1,220.8	15,898

1. The historical data are the averages of the numbers of reports in 6 previous 2 week reporting periods: the corresponding periods of the last 2 years and the periods immediately preceding and following those.

Table 7. Laboratory reports by clinical information for the reporting period 3 June to 16 June 1992

	Encephalitis	Meningitis	Other CNS	Congenital	Respiratory	Gastrointestinal	Hepatic	Skin	Eye	Muscle/joint	Genital	Other/unknown	Total
MEASLES, MUMPS, RUBELLA													
Measles virus								1					1
Rubella virus												1	1
HEPATITIS VIRUSES													
Hepatitis A virus							3					2	5
Hepatitis B virus							42					61	103
Hepatitis C virus							11					73	84
Hepatitis D virus							3						3
ARBOVIRUSES													
Ross River virus								4		28		23	55
Barmah Forest virus												3	3
Dengue not typed						1						4	5

Table 7. Laboratory reports by clinical information for the reporting period 3 June to 16 June 1992, continued

	Encephalitis	Meningitis	Other CNS	Congenital	Respiratory	Gastrointestinal	Hepatic	Skin	Eye	Muscle/joint	Genital	Other/unknown	Total
ADENOVIRUSES													
Adenovirus type 1					1								1
Adenovirus type 2					2								2
Adenovirus type 4									1				1
Adenovirus type 19									1				1
Adenovirus not typed/pending					12	18			2			6	38
HERPES VIRUSES													
Herpes simplex virus type 1					5			45	2		13	7	72
Herpes simplex virus type 2					1			42			65	6	114
Herpes simplex not typed/pending		1				1		14	1		15	10	42
Cytomegalovirus		1		3	33	2	1	1	3		1	27	72
Varicella-zoster virus								14				1	15
Epstein-Barr virus					6	1	2	1		2		45	57
Herpes virus group - not typed								2					2
OTHER DNA VIRUSES													
Papovavirus group												1	1
Parvovirus								2				1	3
PICORNA VIRUS FAMILY													
Coxsackievirus B1					1								1
Echovirus type 6		7											7
Echovirus type 7		1											1
Echovirus type 9		22										4	26
Echovirus type 11		1											1
Echovirus type 17												1	1
Echovirus type 21		2											2
Poliovirus type 1 (uncharacterised)					2							1	3
Poliovirus type 2 (uncharacterised)												3	3
Poliovirus not typed/pending						1						1	2
Rhinovirus (all types)	1				28							2	31
Enterovirus not typed/pending			2		18	10		2	2			6	40
ORTHO/PARAMYXOVIRUSES													
Influenza A virus			1		45							10	56
Influenza A virus H1N1												1	1
Influenza A virus H3N2					22							7	29
Influenza B virus												1	1
Parainfluenza virus type 1					10			1				1	12
Parainfluenza virus type 2					5								5
Parainfluenza virus type 3					10							1	11
Parainfluenza virus typing pending					8							2	10
Respiratory syncytial virus					426							17	443
OTHER RNA VIRUSES													
HIV-1												4	4
Rotavirus					1	49						8	58
Calici virus						3							3
Coronavirus						3						1	4
Small virus (like) particle						1							1

Table 7. Laboratory reports by clinical information for the reporting period 3 June to 16 June 1992, continued

	Encephalitis	Meningitis	Other CNS	Congenital	Respiratory	Gastrointestinal	Hepatic	Skin	Eye	Muscle/joint	Genital	Other/unknown	Total
OTHER													
Chlamydia trachomatis not typed					2				1		53	16	72
Chlamydia pneumoniae					1							2	3
Chlamydia psittaci					2								2
Mycoplasma pneumoniae					23			1				5	29
Coxiella burnetti (Q fever)					1							7	8
Rickettsia australis												3	3
Treponema pallidum												1	1
Toxoplasma gondii												1	1
TOTAL	1	35	3	3	665	90	62	130	13	31	147	377	1557

Table 8. Laboratory reports by contributing laboratories for the reporting period 3 June to 16 June 1992

STATE	Laboratory	Reports
Australian Capital Territory	Woden Valley Hospital, Canberra	68
New South Wales	Institute of Clinical Pathology & Medical Research, Westmead	202
	Prince Henry/Prince of Wales Hospitals, Sydney	36
	Royal Alexandra Hospital for Children, Camperdown	47
	Liverpool Hospital	69
Queensland	Dr TB Lynch, Pathologist, Rockhampton	97
	State Health Laboratory, Brisbane	223
South Australia	Institute of Medical & Veterinary Science, Adelaide	119
Tasmania	Royal Hobart Hospital, Hobart	4
Victoria	Fairfield Hospital, Melbourne	208
	Microbiological Diagnostic Unit, University of Melbourne	6
	Royal Childrens Hospital, Melbourne	137
Western Australia	Princess Margaret Hospital, Perth	108
	State Health Laboratory Services, Perth	233
TOTAL		1557