



Communicable Diseases Intelligence

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VIRUSES, CHLAMYDIAS, COXIELLAS, RICKETTSIAS AND MYCOPLASMAS REPORTING SCHEME: A total of 1,159 reports were processed during this period.

Four cases of Q fever (2 males, 1 female, 1 sex not stated) were reported during this period. Ages ranged from 26 to 67 years. No exposure details were provided.

Forty-one reports of influenza A not typed, 5 of influenza A(H3N2), 1 of influenza A(H1N1), and 39 of influenza B were received during this period. This is only the second report of influenza A(H1N1) received by the CDI this season. The isolate has been sent for confirmation and strain typing.

OVERSEAS BRIEFS:

1. MENINGOCOCCAL MENINGITIS - MALAWI

A total of 444 cases (35 deaths) of meningococcal meningitis (possibly types A and C) have been notified in Malawi. Because the cases are scattered throughout the country, it has not been considered necessary to instigate local vaccination programs.

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2. DENGUE FEVER - SUMMARY OF 1989 REPORTS

So far this year outbreaks or epidemics of dengue fever have been reported in French Polynesia, New Caledonia, Wallis, Tuvalu, Niue, Malaysia, Singapore and Vanuatu.

In French Polynesia an epidemic of dengue serotype 1 commenced in December 1988 and peaked in February 1989. At this stage no deaths and no cases of haemorrhagic fever had been reported. From February the number of cases of dengue 1 waned. However, cases of dengue type 3 were reported from April 1989, reaching epidemic proportions by October 1989 with haemorrhagic symptoms being seen in up to 49% of cases, especially among children.

In New Caledonia an epidemic of dengue commenced in January 1989 and declined from February to April. Cases were predominately dengue 3 serotype, although some cases of dengue 1 and 4 were also reported. The epidemic was estimated to reach 8% of the population with at least 2 deaths confirmed and another possible 5 - 10 deaths reported.

An outbreak of dengue 2 was reported in Niue in January and February, and cases of dengue 3 in Tuvalu in March.

In April an outbreak of dengue type 3 occurred in Wallis and Futuna, with 25 cases of dengue haemorrhagic fever and 1 death reported.

At the same time an epidemic of dengue 1 commenced in Vanuatu. In Vila, the capital, the epidemic peaked in June, with 499 cases reported in one week, bringing number of cases in Vila up to that time to 3,000 including 54 cases of dengue haemorrhagic syndrome, 15 of whom developed shock syndrome. In the outlying areas of Vanuatu, the epidemic peak was later than in Vila. A waning in the epidemic followed with a resurgence of cases in August increasing sharply in October. The situation is now described as being at 'low epidemic level'.

At the end of April, 143 cases of dengue fever, 50 cases of dengue haemorrhagic fever, and 4 deaths were reported in Malaysia. Cases were reported from Jahore State, Pahang State and the Federal Territory.

An outbreak of dengue type 4 commenced in mid-May in Singapore, peaking in mid-July. By 2 September, 313 cases of dengue fever and 312 cases of dengue haemorrhagic fever had been reported.

During 1989, the South Pacific Commission received reports of cases of dengue in Kiribati in February, March and May 1989 and in Western Samoa from May to July 1989, in addition to these reports. However, comparison of the timing of reports of previously known outbreaks indicates that this timing is based on date of reporting rather than of occurrence.

Dengue fever is a mosquito-borne viral disease transmitted by *Aedes spp.*. Cases of dengue fever are relatively rare in Australia, although the major vector, *Aedes aegypti* is present in parts of northern Australia. The last epidemic in Australia occurred in 1981-82 [1]. This disease should be considered in the differential diagnosis of patients with fever, chills, severe headache and muscle and joint pain who have a history of

travel in Asia, the Pacific, and South America, particularly to areas where outbreaks are being reported. The incubation period is generally 5 - 8 days.

Persons consulting physicians for advice/disease prophylaxis prior to overseas travel should be counselled on the following methods of avoiding mosquito bites:

- . use of mosquito nets if sleeping in non-airconditioned accommodation;
- . use of 'knockdown' sprays or coils to kill mosquitoes indoors;
- . wearing of light coloured clothing (long dresses or long sleeved shirts buttoned at the wrist and long trousers) since dark coloured clothing attracts mosquitoes;
- . avoiding the use of perfume, cologne and after-shave lotion which also attract mosquitoes;
- . use of an effective insect repellent.

N,N-Diethyl-m-toluamide (DEET) is the most effective of the currently available mosquito repellents. Products containing up to 20% DEET should be considered as a first line prophylactic measure. However, travellers should be warned that prolonged or excessive use can be dangerous, particularly in children (see following article). In the rare cases where DEET causes dermatological or systemic adverse reactions, products containing ethylhexanediol are recommended.

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SEIZURES TEMPORALLY ASSOCIATED WITH THE USE OF DEET INSECT REPELLENT - NEW YORK AND CONNECTICUT, USA

(Based on MMWR 1989;38:678-81)

In August 1989, epidemiologists from the New York State Department of Health (NYSDH) investigated five reports of generalised seizures temporally associated with topical use of N,N-diethyl-m-toluamide (DEET). Three of the patients, one from New York and two from Connecticut, were reported by a paediatric neurologist who practices in both states. One case was reported initially to an entomologist in New York, and one was reported directly to the NYSDH. The cases occurred from June to August 1989.

The patients, four boys aged 3-7 years and one 29-year-old man, had few prodromal symptoms and recovered quickly. All five had unremarkable medical histories, and none had had a previous seizure or neurological event. All had normal nonfocal neurological examinations after their seizures, and four had normal complete laboratory examinations and normal computerised tomography and/or magnetic resonance imaging examinations. Each had had topical cutaneous exposures to varying concentrations of DEET; four had had fewer than three applications. The interval between last use of DEET and onset of seizures ranged from 8 to 48 hours. One patient developed urticaria before his seizure; he was one of two patients who developed an urticarial reaction to phenytoin administered to control seizures.

While reinforcing the importance of DEET in preventing disease, health officials in New York, Connecticut, and New Jersey issued a health alert on 22 August advising caution in the use of DEET-containing repellents. The NYSDH is planning to conduct epidemiological studies to evaluate the association between DEET and neurological events.

MMWR Editorial Comment

DEET has been marketed in the United States since 1956 and is used by an estimated 50-100 million persons each year. Since 1961, at least six cases of toxic systemic reactions from repeated cutaneous exposure to DEET have been reported [1-6]. Six girls, ranging in age from 17 months to 8 years, developed behavioural changes, ataxia, encephalopathy, seizures, and/or coma after repeated cutaneous exposure to DEET; three died. Another six systemic toxic reactions have been reported following ingestion of DEET [7]. Additionally, episodes of confusion, irritability, and insomnia have been reported by Everglades National Park employees following repeated and prolonged use of DEET [8].

DEET is partially absorbed through the skin and has been used to enhance dermal delivery of other drugs [9]. Adverse reactions include allergic responses, direct neurotoxicity, and dermatitis. One of the girls who died after dermal exposure was partially deficient in the enzyme ornithine carbamoyltransferase [3]; DEET may interfere with the urea cycle metabolic pathway [10].

For health officials in New York and Connecticut, two of the states where Lyme Disease, a tick-borne disease caused by the spirochete *Borrelia burgdorferi*, is of growing concern, inquiries about the potential adverse effects of insect repellents have increased. Recent anecdotal reports of seizures temporally associated with the use of DEET have heightened public awareness of DEET's potential adverse effects.

Anecdotal reports of seizures are difficult to interpret. None of the recent cases in New York and Connecticut have been clearly established as DEET toxicity. In contrast to cases described in the medical literature, the New York and Connecticut patients were all male, DEET exposure was less intense, few prodromal symptoms or encephalopathy were seen, and recovery was more rapid and complete. With the dramatic increase in the prevalence of DEET use in areas with endemic Lyme Disease, the reported cases of seizures temporally related to DEET use may be coincidental. However, these cases may represent a different, previously unreported spectrum of toxic reactions. Careful toxicological and epidemiological studies must be conducted, including adequate documentation of DEET levels in affected and unaffected persons.

Clinicians evaluating patients with unexplained seizures should consider the possibility of exposure to DEET. However, since the exact circumstances under which DEET-related neurotoxicity may occur are unclear, DEET should not be accepted as the cause of a seizure until appropriate evaluation has reliably excluded other possible aetiologies.

The optimal concentration of DEET for prevention of tick bites is unknown. However, repellents containing 20%-30% DEET applied to clothing are approximately 90% effective in preventing tick attachment [11]. To minimise the possibility of adverse reactions to DEET, the following precautions are suggested:

- . Apply repellent sparingly only to exposed skin or clothing.
- . Avoid applying high-concentration products to the skin, particularly of children.
- . Do not inhale or ingest repellents or get them into the eyes.
- . Wear long sleeves and long pants, when possible, and apply repellents to clothing to reduce exposure to DEET.
- . Avoid applying repellents to portions of children's hands that are likely to have contact with eyes or mouth.
- . Never use repellents on wounds or irritated skin.
- . Use repellents sparingly; one application will last 4-8 hours. Saturation does not increase efficacy.
- . Wash repellent-treated skin after coming indoors.
- . If a suspected reaction to insect repellents occurs, wash treated skin, and call a physician. Take the repellent can to the physician.

CDI Editorial Comment

The use of personal insect repellents is an important component of prevention of diseases which are transmitted by insect vectors eg epidemic polyarthrits (caused by Ross River virus), Australian Encephalitis (previously known as Murray Valley encephalitis) and malaria, which are all transmitted by mosquitoes. DEET is the most efficient repellent for use against mosquitoes and is a component of most insect repellents and sunscreen/repellent combinations.

The National Health and Medical Research Council (NHMRC) has reviewed data on DEET toxicity and noted that this is low, with no reproductive, teratogenic, carcinogenic or mutagenic effects having been reported despite widespread use over many years. However, users should be warned that prolonged or excessive use can be dangerous, particularly in children.

The NHMRC has recommended that insect repellents should contain not more than 20% DEET [12] and that preparations containing over 20% DEET carry a warning. It is, however, advisable to check the label of any insect repellent to ensure that the product does not contain more than 20% DEET since stock of higher concentration formulations (up to 70%) which do not carry a warning may be available.

A list of commonly available insect repellents and sunscreens has recently been published in the NHMRC 'Malaria Guidelines for Medical Practitioners' [13].

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GONOCOCCAL SURVEILLANCE, AUSTRALIA: 1 APRIL - 30 JUNE 1989

(Contributed by Australian Gonococcal Surveillance Programme - [AGSP] Co-ordinator Dr J W Tapsall, The Prince of Wales Hospital, Sydney NSW 2031)

In the three months ended 30 June 1989, a total of 513 strains of *Neisseria gonorrhoeae* was examined in reference laboratories throughout Australia. The penicillin sensitivity of these isolates was determined by means of a standardised technique [1]. Table 1 shows the percentage of strains in each mainland capital which fell into the categories of 'fully sensitive' or 'less sensitive' to penicillin (see footnotes to Table 1) or which were penicillinase producing strains (PPNG). Smaller numbers of isolates in other categories and data from Hobart, Canberra and Darwin are not included in the table. Strains relatively resistant to penicillin (MIC 1.0 mg/L or more), by virtue of chromosomally controlled mechanisms in the organism, were present in significant numbers in Melbourne, where they represented 9.8% of all isolates. Strains with this level of resistance accounted for 3% of isolates in Sydney but were not isolated in other centres. Patients infected with strains of this type have higher rates of treatment failure when standard penicillin-based regimens are used.

There were 101 isolates of PPNG in this quarter, slightly less than the 124 PPNG reported in the corresponding quarter in 1988. Just under half of these isolates (49) were from patients in Sydney and 42 of these were locally acquired infections. In Melbourne and Brisbane acquisition of PPNG by 'local' contact was reported in a smaller number of cases. Cases of PPNG recognised in other centres were the result of overseas contact. Thailand and the Philippines remain the main centres where infections with PPNG are acquired overseas, and all imported cases of PPNG were acquired in the Pacific basin.

Table 1: Penicillin sensitivity of isolates of *N. gonorrhoeae*
1 April - 30 June 1989

<u>Centre</u>	<u>Percentage of isolates</u>		
	<u>Sensitive*</u>	<u>Less Sensitive**</u>	<u>PPNG</u>
Brisbane	14.7 (22.6)	56.8 (55.2)	17.9 (6.9)
Sydney	2.3 (4.2)	50.0 (36.1)	37.1 (47.5)
Melbourne	2.8 (7.3)	66.2 (43.8)	17.6 (20.2)
Adelaide	12.5 (7.7)	78.1 (59.7)	3.1 (15.4)
Perth	6.7 (8.9)	64.4 (51.1)	20.0 (11.1)

* Sensitive MIC = 0.004-0.016 mg/L

** Less sensitive MIC = 0.06-0.25 mg/L

Figures in parenthesis represent data for the equivalent in 1987.

This report completes the eighth year of AGSP reports in the CDI. In this time there have been significant changes in the penicillin sensitivity of gonococcal isolates due both to increases in chromosomally-controlled intrinsic resistance and to the emergence of PPNG [2]. Another pattern observed by the AGSP has been a significant decline in the number of gonococcal isolates, and changes have also been observed in various sub-groups of patients [3]. In this past year there has been relatively little change in the overall patterns of gonococcal resistance to the penicillins and the number of isolates of gonococci in each quarter has remained relatively stable.

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VARICELLA OUTBREAK IN A WOMEN'S PRISON - KENTUCKY, USA

During January and February 1989, three cases of varicella (chickenpox) occurred among inmates at the Federal Correctional Institution in Lexington, Kentucky. This all-women prison is a 1200-bed facility with an onsite hospital. At the time of the outbreak, 1276 inmates were housed in the facility; approximately one quarter were Hispanic (primarily from Central and South America); 36 (3%) were pregnant. Thirty-two (3%) inmates were seropositive by enzyme-linked immunosorbent assay (ELISA) and Western blot for human immunodeficiency virus (HIV) infection, including six persons with acquired immune deficiency syndrome (AIDS).

The first case of varicella developed on 8 January in a 25-year-old US-born black woman who had been on furlough in New Jersey with her 8-year-old daughter who had chickenpox. The second case occurred on 1 February in a 23-year-old Central American woman; she had given the first patients hair a permanent wave within the 24 hours before the first patient developed a rash. The third case was identified on 19 February in a 19-year-old US-born Hispanic woman who also has severe juvenile

rheumatoid arthritis. The latter two women attended the same class during late January.

The third patient lived in the chronic-care unit of the prison hospital with 17 other women, including two with AIDS and one receiving low-dose steroids for treatment of systemic lupus erythematosus. She potentially exposed two groups of contacts. The first group comprised other inmates in the chronic-care unit, the unit's medical staff, and inmate workers. To prevent further transmission, persons with uncertain histories of previous chickenpox infection were not permitted to enter the unit. Three nurses who were uncertain of their histories were excluded from the unit pending results of their varicella-zoster (VZ) antibody titre tests. In addition, 12 patients and four inmate workers from the chronic-care unit were identified from histories as possibly not immune.

The second group of contacts comprised all other identifiable social and classroom contacts of the third patient and included over 200 inmates who attended the same programs or classes during the 3 days before she developed symptoms. Of this group, 100 were uncertain about histories of previous varicella infection, including 40 with self-identified risk behaviours for HIV infection and one who may have been pregnant. Serum specimens were obtained from 116 of these inmates and three staff members to measure VZ antibody titres. Because of the time required to process the specimens, all potentially susceptible inmates in this second group of contacts were quarantined in a separate unit within the prison until their serological results became available.

Overall, 115 (99%) of the 116 persons with evaluative results* were immune to VZ (immunity defined as titres of 1:8 or more by immunofluorescent antibody [IFA] measurement); the one person who was confirmed susceptible to VZ after duplicate IFA testing remained asymptomatic. All pregnant women, AIDS patients, and staff were immune. In addition, all 40 persons reportedly at risk for HIV infection were negative for HIV antibody on ELISA testing. No cases of varicella have occurred since the third case.

MMWR Editorial Note:

In the United States, exposure to and infection with the highly communicable VZ virus is virtually unavoidable [1]. VZ virus causes both varicella (the manifestation of primary infection in a susceptible person) and zoster (the result of reactivation of latent virus); patients with either disease may transmit the virus to susceptible persons [1-3]. An estimated 3.5 million cases of varicella and 300,000 cases of zoster occur in the United States annually [2].

Varicella can be life threatening, particularly in adults, pregnant women, neonates, and immunocompromised persons. VZ infection in pregnancy may also produce fetal infection and an array of congenital abnormalities characterised as congenital varicella syndrome [4]. Zoster occurs and can be severe in

* Three women had "interfering substances" in their serum preventing a determination of VZ antibody presence, but subsequent interviews with family members established a childhood history of chickenpox in all three cases.

HIV-infected persons [5]. Persons from rural tropical and subtropical regions are less likely than persons from temperate zones to be infected as children, leaving them susceptible as adults [6]. Thus, in this prison population, increased risk existed for transmission and severe health effects.

In this investigation, the estimated level of immunity for the inmate population was at least 99%. Based on this nonrandom sample from the population of 1267 inmates, at most, 13 persons were possibly susceptible to varicella before the onset of disease in the first case. Nonetheless, the close confines and extensive socialisation in a prison maximise the potential spread of a highly contagious disease, such as varicella, despite high levels of immunity.

Introduction and subsequent transmission of the VZ virus among patients and staff can be reduced in health-care settings such as in this prison. CDC, Atlanta, has developed isolation precautions for hospitalised patients who either have active disease or have been exposed to varicella or zoster [7]. CDC has also issued recommendations to minimise virus transmission to and from hospital personnel [8]; in institutions where varicella is prevalent or where there are many high-risk patients, it may be useful to screen those personnel who have a negative or equivocal history of varicella for the presence of serum antibodies to VZ virus to document susceptibility or immunity (persons with a positive history can be considered immune). In the absence of a licensed vaccine against VZ, efforts should be taken to maximise the effectiveness of existing recommendations for control of VZ virus infections.

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CORRECTION: CDI 89/21, ARTICLE ON CREUTZFELDT-JAKOB DISEASE

The following errors were made in the CJD article published in *CDI* 89/21 pages 7-8:

- . First line of first paragraph: the patient was admitted to hospital in July 1987 not July 1989.
- . The correct journal citation for reference 1 is: *MMWR* 1987; 39:49-55.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

VIRAL IDENTIFICATIONS FROM CONTRIBUTING LABORATORIES
BASED ON DATE OF REPORTING

PERIOD 26/10/89 TO 8/11/89

- | | |
|-------------------------------------|-----------------------------------|
| 1. CODE 019 - FAIRFIELD(VIC) | 5. CODE 112 - ICPMR(NSW) MVH(ACT) |
| 2. CODE 065 - STATE LAB(WA) PMH(WA) | 6. CODE 113 - PHH POW(NSW) |
| 3. CODE 110 - IMVS(SA) | 7. CODE 114 - RAHC(NSW) |
| 4. CODE 111 - RCH(VIC) | 8. CODE 115 - STATE LAB(QLD) |

	019	065	110	111	112	113	114	115	TOTAL
0100 ADENOVIRUS NOT TYPED	1	3	1	0	4	9	1	13	32
0101 ADENOVIRUS TYPE 1	0	0	3	4	4	0	0	0	11
0102 ADENOVIRUS TYPE 2	5	2	0	16	7	0	0	0	30
0103 ADENOVIRUS TYPE 3	3	1	2	6	1	1	1	0	15
0104 ADENOVIRUS TYPE 4	4	0	0	0	0	0	0	0	4
0105 ADENOVIRUS TYPE 5	0	1	0	2	2	0	0	0	5
0107 ADENOVIRUS TYPE 7	1	0	0	0	0	0	0	0	1
0108 ADENOVIRUS TYPE 8	0	1	0	0	0	0	0	0	1
0109 ADENOVIRUS TYPE 9	0	1	0	0	0	0	0	0	1
0111 ADENOVIRUS TYPE 11	2	0	0	0	3	0	0	0	5
0130 ADENOVIRUS TYPE 30	0	0	0	0	1	0	0	0	1
0137 ADENOVIRUS TYPE 37	2	0	0	0	0	0	0	0	2
0199 ADENOVIRUS TYPING PENDING	1	0	0	14	0	0	3	0	18
0201 INFLUENZA A VIRUS	4	8	1	0	25	3	0	0	41
0202 INFLUENZA A VIRUS SUBTYPE H3N2	0	0	0	1	0	0	0	4	5
0203 INFLUENZA B VIRUS	4	1	4	9	13	3	0	5	39
0206 INFLUENZA A H1N1	0	0	0	0	1	0	0	0	1
0299 INFLUENZA VIRUS - TYPING PENDING	0	2	0	0	0	0	0	0	2
0301 PARAINFLUENZA VIRUS TYPE 1	0	4	0	0	1	0	0	0	5
0303 PARAINFLUENZA VIRUS TYPE 3	1	4	11	13	15	0	2	11	57
0399 PARAINFLUENZA VIRUS TYPING PENDING	0	1	0	0	0	0	0	0	1
0400 RESPIRATORY SYNCYTIAL VIRUS (R)	2	3	2	12	0	1	1	3	24
0500 RHINOVIRUS (ALL TYPES)	4	12	14	9	0	0	0	0	39
0600 MYCOPLASMA PNEUMONIAE	3	4	1	13	2	1	0	0	24
0700 ORNITHOSIS-PSITTACOSIS	4	0	0	0	0	0	0	0	4
0804 COXSACKIEVIRUS A4	0	1	0	0	0	0	0	0	1
0901 COXSACKIEVIRUS B1	0	1	0	0	0	0	0	0	1
0903 COXSACKIEVIRUS B3	0	0	0	3	0	0	0	0	3
0904 COXSACKIEVIRUS B4	0	3	1	0	0	0	0	0	4
1003 ECHOVIRUS TYPE 3	0	1	0	0	0	0	0	0	1
1004 ECHOVIRUS TYPE 4	0	0	0	1	0	0	0	0	1
1011 ECHOVIRUS TYPE 11	3	0	0	0	0	0	0	0	3
1022 ECHOVIRUS TYPE 22	0	0	1	0	1	0	0	0	2
1028 ECHOVIRUS TYPE 28 = RHINO VIRUS	0	0	0	0	0	0	1	0	1
1030 ECHOVIRUS TYPE 30	0	1	0	0	0	0	0	0	1
1099 ECHOVIRUS TYPING PENDING	0	3	0	0	0	0	0	0	3
1100 POLIOVIRUS NOT TYPED	0	0	0	6	0	4	0	0	10
1101 POLIOVIRUS TYPE 1	0	0	0	0	3	0	0	0	3
1102 POLIOVIRUS TYPE 2	0	0	1	0	0	0	0	0	1
1103 POLIOVIRUS TYPE 3	1	0	1	0	0	0	0	0	2
1104 POLIOVIRUS - MIXED VACCINAL ST	0	2	0	0	0	0	0	0	2
1200 MUMPS VIRUS	0	0	0	0	2	0	0	0	2
1300 HERPES VIRUS GROUP - NOT TYPED	2	3	0	0	8	0	0	0	13
1301 HERPES SIMPLEX VIRUS - NOT TYP	0	3	0	0	35	0	0	62	100
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	0	4	21	0	53	3	1	0	82
1303 VARICELLA-ZOSTER VIRUS	3	5	2	1	4	0	0	2	17
1306 HERPES SIMPLEX TYPE 1	48	32	15	1	5	5	0	1	107
1307 HERPES SIMPLEX TYPE 2	64	59	30	0	15	9	0	2	179
1399 HERPES VIRUS TYPING PENDING	0	0	0	6	0	0	0	0	6
1401 COXIELLA BURNETII	0	0	1	0	3	0	0	0	4
1502 PICORNIA VIRUS - NOT TYPED = E	0	1	0	0	0	1	0	10	12
1521 MEASLES VIRUS	4	0	0	0	1	0	0	0	5
1522 RUBELLA VIRUS	14	4	13	1	27	0	0	0	59
1532 HEPATITIS B ANTIGEN	19	5	18	0	39	7	0	14	102
1535 HEPATITIS A ANTIBODY	4	2	9	0	0	0	0	3	18
1541 CHLAMYDIA A - C. TRACHOMATIS	0	41	22	0	20	0	0	50	133
1555 PAPOVAVIRUS GROUP (PAPILLOMA -	0	0	0	0	0	2	0	0	2
1556 CMV - CYTOMEGALOVIRUS	31	13	2	6	28	1	3	4	88
1564 ROTAVIRUS	3	5	67	28	19	26	10	2	160
1565 CALICI VIRUS	0	0	0	0	1	0	0	0	1
1566 NORWALK AGENT	0	0	0	0	1	0	0	0	1
1599 ENTEROVIRUS TYPING PENDING	0	0	0	3	0	2	0	0	5
9902 POXVIRUS GROUP NOT TYPED	1	0	0	0	0	0	0	0	1
9990 AUSTRALIAN ENCEPHALITIS	0	1	0	0	0	0	0	0	1
9992 ROSS RIVER VIRUS	0	0	2	0	9	0	0	0	11
9993 ASTROVIRUS	0	0	0	0	1	0	0	0	1
9994 SMALL VIRUS (LIKE) PARTICLE	0	0	0	0	0	0	2	0	2
TOTAL	238	238	245	155	354	78	25	186	1519

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

VIRAL IDENTIFICATIONS BY CLINICAL INFORMATION TABLE 1

PERIOD 26/10/89 TO 8/11/89

- 1. CODE 00, 99 - NO ILL OR DATA
- 2. CODE 01, 02, 11, 12 - RESPIRATORY
- 3. CODE E3 - ENCEPHALITIS
- 4. CODE M3 - MENINGITIS
- 5. CODE 04 - PARALYSIS
- 6. CODE 05, 13 - CNS OTHER UNSPEC
- 7. CODE 07, 49 - GASTRO INTESTINAL
- 8. CODE 17, 47 - HEPATIC
- 9. CODE 19 ... - CVS
- 10. CODE 89 ... - URINARY TRACCT
- 11. CODE 06 ... - SKIN MUCOUS

	1	2	3	4	6	7	8	9	10	11	TOTAL
0100 ADENOVIRUS NOT TYPED	1	7	1	0	0	21	0	0	0	1	31
0101 ADENOVIRUS TYPE 1	1	5	0	0	0	2	0	0	0	1	9
0102 ADENOVIRUS TYPE 2	4	16	0	0	0	2	0	0	0	0	22
0103 ADENOVIRUS TYPE 3	1	6	1	0	0	1	0	0	0	0	9
0105 ADENOVIRUS TYPE 5	1	2	0	0	0	1	0	0	0	0	4
0107 ADENOVIRUS TYPE 7	0	1	0	0	0	0	0	0	0	0	1
0111 ADENOVIRUS TYPE 11	0	0	0	0	0	2	0	1	0	0	3
0130 ADENOVIRUS TYPE 30	0	0	0	0	0	1	0	0	0	0	1
0199 ADENOVIRUS TYPING PENDING	0	13	0	0	0	1	0	0	0	0	14
0201 INFLUENZA A VIRUS	4	29	0	0	1	0	0	2	0	0	36
0202 INFLUENZA A VIRUS SUBTYPE H3N2	0	4	0	0	0	0	0	0	0	0	4
0203 INFLUENZA B VIRUS	3	27	0	0	0	0	0	0	0	0	30
0206 INFLUENZA A H1N1	0	1	0	0	0	0	0	0	0	0	1
0299 INFLUENZA VIRUS - TYPING PENDING	0	2	0	0	0	0	0	0	0	0	2
0301 PARAINFLUENZA VIRUS TYPE 1	2	2	0	0	0	0	0	0	0	1	5
0303 PARAINFLUENZA VIRUS TYPE 3	7	47	0	0	0	0	0	0	0	0	54
0399 PARAINFLUENZA VIRUS TYPING PENDING	0	1	0	0	0	0	0	0	0	0	1
0400 RESPIRATORY SYNCYTIAL VIRUS (R)	0	24	0	0	0	0	0	0	0	0	24
0500 RHINOVIRUS (ALL TYPES)	0	34	0	1	0	0	0	0	0	0	35
0600 MYCOPLASMA PNEUMONIAE	0	21	0	0	0	0	0	0	0	0	21
0700 ORNITHOSIS-PSITTACOSIS	2	2	0	0	0	0	0	0	0	0	4
0804 COXSACKIEVIRUS A4	0	0	0	0	0	1	0	0	0	0	1
0901 COXSACKIEVIRUS B1	0	0	0	0	0	1	0	0	0	0	1
0903 COXSACKIEVIRUS B3	0	1	0	0	0	0	0	0	0	0	1
0904 COXSACKIEVIRUS B4	0	1	0	0	0	2	0	0	0	0	3
1004 ECHOVIRUS TYPE 4	0	0	1	0	0	0	0	0	0	0	1
1011 ECHOVIRUS TYPE 11	0	0	0	2	0	0	0	0	0	1	3
1022 ECHOVIRUS TYPE 22	1	1	0	0	0	0	0	0	0	0	2
1028 ECHOVIRUS TYPE 28 = RHINO VIRUS	0	1	0	0	0	0	0	0	0	0	1
1030 ECHOVIRUS TYPE 30	0	0	0	1	0	0	0	0	0	0	1
1099 ECHOVIRUS TYPING PENDING	0	3	0	0	0	0	0	0	0	0	3
1100 POLIOVIRUS NOT TYPED	0	1	0	0	0	4	0	0	0	0	5
1101 POLIOVIRUS TYPE 1	1	0	0	0	0	1	0	0	0	0	2
1102 POLIOVIRUS TYPE 2	0	0	0	0	0	1	0	0	0	0	1
1103 POLIOVIRUS TYPE 3	0	0	0	0	0	1	0	0	0	0	1
1104 POLIOVIRUS - MIXED VACCINAL ST	1	0	0	0	0	0	0	0	0	0	1
1200 MUMPS VIRUS	1	0	1	0	0	0	0	0	0	0	2
1300 HERPES VIRUS GROUP - NOT TYPED	0	0	0	0	0	0	0	0	0	10	10
1301 HERPES SIMPLEX VIRUS - NOT TYPED	13	4	0	0	0	0	0	0	0	37	54
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	14	3	1	3	0	2	6	1	0	0	30
1303 VARICELLA-ZOSTER VIRUS	1	3	0	0	0	0	0	0	0	12	16
1306 HERPES SIMPLEX TYPE 1	0	2	0	0	1	0	0	0	0	61	64
1307 HERPES SIMPLEX TYPE 2	5	0	0	0	0	0	0	0	0	70	75
1399 HERPES VIRUS TYPING PENDING	0	1	0	0	0	0	0	0	0	4	5
1502 PICORNAVIRUS - NOT TYPED = E	0	4	0	0	1	7	0	0	0	0	12
1521 MEASLES VIRUS	3	0	0	0	0	0	0	0	0	1	4
1522 RUBELLA VIRUS	8	0	0	0	0	0	0	0	0	21	29
1532 HEPATITIS B ANTIGEN	50	0	0	0	0	0	40	0	0	0	90
1535 HEPATITIS A ANTIBODY	4	0	0	0	0	0	13	0	0	0	17
1541 CHLAMYDIA A - C. TRACHOMATIS	12	1	0	0	0	0	0	0	0	0	13
1555 PAPOVAVIRUS GROUP (PAPILLOMA -	0	0	0	0	0	0	0	0	2	0	2
1556 CMV - CYTOMEGALOVIRUS	9	15	0	1	0	1	3	0	5	0	34
1564 ROTAVIRUS	5	0	0	0	0	155	0	0	0	0	160
1565 CALICI VIRUS	0	0	0	0	0	1	0	0	0	0	1
1566 NORWALK AGENT	1	0	0	0	0	0	0	0	0	0	1
1599 ENTEROVIRUS TYPING PENDING	0	2	1	0	0	2	0	0	0	0	5
9902 POXVIRUS GROUP NOT TYPED	0	0	0	0	0	0	0	0	0	1	1
9990 AUSTRALIAN ENCEPHALITIS	0	0	1	0	0	0	0	0	0	0	1
9992 ROSS RIVER VIRUS	1	0	0	0	0	0	0	1	0	1	3
9993 ASTROVIRUS	0	0	0	0	0	1	0	0	0	0	1
9994 SMALL VIRUS (LIKE) PARTICLE	0	0	0	0	0	2	0	0	0	0	2
TOTAL	156	287	7	8	3	213	62	5	7	222	970

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

VIRAL IDENTIFICATIONS BY CLINICAL INFORMATION TABLE 2

PERIOD 26/10/89 TO 8/11/89

- | | |
|--------------------------------------|-----------------------------|
| 12. CODE 10 - EYE | 17. CODE 69 - CONGENITAL |
| 13. CODE 59 - GENITAL | 18. CODE P8 - PUO |
| 14. CODE 39 - ENDOCRINE/SALIVARY GL. | 19. CODE G8 - FEVER/MALAISE |
| 15. CODE 38 - RETICULO-ENDOTHELIAL | 20. CODE 09 - OTHER |
| 16. CODE 29 - MUSCLE/JOINT | 21. CODE A1 - SIDS |

	12	13	14	16	17	18	19	20	21	TOTAL
0100 ADENOVIRUS NOT TYPED	0	0	0	0	0	0	0	1	0	1
0101 ADENOVIRUS TYPE 1	0	0	0	0	0	1	0	1	0	2
0102 ADENOVIRUS TYPE 2	0	0	0	0	0	1	6	1	0	8
0103 ADENOVIRUS TYPE 3	4	1	0	0	0	1	0	0	0	6
0104 ADENOVIRUS TYPE 4	4	0	0	0	0	0	0	0	0	4
0105 ADENOVIRUS TYPE 5	0	0	0	0	0	0	0	1	0	1
0108 ADENOVIRUS TYPE 8	0	0	0	0	1	0	0	0	0	1
0109 ADENOVIRUS TYPE 9	0	0	0	0	1	0	0	0	0	1
0111 ADENOVIRUS TYPE 11	0	0	0	0	0	0	1	1	0	2
0137 ADENOVIRUS TYPE 37	1	0	0	0	0	0	0	1	0	2
0199 ADENOVIRUS TYPING PENDING	0	0	0	0	0	0	3	1	0	4
0201 INFLUENZA A VIRUS	0	0	0	0	0	2	3	0	0	5
0202 INFLUENZA A VIRUS SUBTYPE H3N2	0	0	0	0	0	0	1	0	0	1
0203 INFLUENZA B VIRUS	0	0	0	1	0	4	4	0	0	9
0303 PARAINFLUENZA VIRUS TYPE 3	0	0	0	0	0	0	3	0	0	3
0500 RHINOVIRUS (ALL TYPES)	0	0	0	0	0	0	1	3	0	4
0600 MYCOPLASMA PNEUMONIAE	0	0	0	0	0	0	1	2	0	3
0903 COXSACKIEVIRUS B3	0	0	0	0	0	0	1	1	0	2
0904 COXSACKIEVIRUS B4	0	0	0	0	0	0	1	0	0	1
1003 ECHOVIRUS TYPE 3	0	0	0	0	0	0	0	1	0	1
1100 POLIOVIRUS NOT TYPED	0	0	0	1	0	0	0	0	4	5
1101 POLIOVIRUS TYPE 1	0	0	0	0	0	0	0	0	1	1
1103 POLIOVIRUS TYPE 3	0	0	0	0	0	0	0	0	1	1
1104 POLIOVIRUS - MIXED VACCINAL ST	0	0	0	0	0	0	0	1	0	1
1300 HERPES VIRUS GROUP - NOT TYPED	0	3	0	0	0	0	0	0	0	3
1301 HERPES SIMPLEX VIRUS - NOT TYP	1	44	0	1	0	0	0	0	0	46
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	0	0	34	1	0	3	5	9	0	52
1303 VARICELLA-ZOSTER VIRUS	0	0	0	0	0	0	0	1	0	1
1306 HERPES SIMPLEX TYPE 1	7	31	0	0	0	0	4	1	0	43
1307 HERPES SIMPLEX TYPE 2	1	100	0	0	0	0	0	3	0	104
1399 HERPES VIRUS TYPING PENDING	0	0	0	0	0	0	1	0	0	1
1401 COXIELLA BURNETII	0	0	0	0	0	2	2	0	0	4
1521 MEASLES VIRUS	0	0	0	0	0	0	1	0	0	1
1522 RUBELLA VIRUS	0	0	4	5	0	0	3	18	0	30
1532 HEPATITIS B ANTIGEN	0	0	0	0	0	0	0	12	0	12
1535 HEPATITIS A ANTIBODY	0	0	0	0	0	0	0	1	0	1
1541 CHLAMYDIA A - C. TRACHOMATIS	0	120	0	0	0	0	0	0	0	120
1556 CMV - CYTOMEGALOVIRUS	2	0	4	0	6	1	1	39	1	54
9992 ROSS RIVER VIRUS	0	0	0	6	0	1	0	1	0	8
TOTAL	20	299	42	15	8	16	42	100	7	549

NOTIFIABLE DISEASES REPORTED IN AUSTRALIA

Period 2: 29 January 1989 - 25 February 1989

DISEASE	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	TOTAL	CUMULATIVE TOTAL
Amoebiasis (a)	-	-	-	6	-	-	-	-	6	10*
Ankylostomiasis (a)	-	-	(b)	-	4	-	(b)	-	4	7
Anthrax (a)	-	-	-	-	-	-	-	-	-	-
Arbovirus infection (a)	100	16	191	14	177	-	10	-	508	752
Brucellosis (a)	-	-	-	-	-	-	-	-	-	3
Campylobacter infection (a)	184	(b)	(b)	101	22	(b)	6	1	314	615
Chancroid (a)	-	-	-	(b)	-	(b)	-	(b)	-	-
Cholera	-	-	-	-	-	-	-	-	-	-
Congenital rubella syndrome	-	(b)	(b)	-	-	(b)	-	(b)	-	-
Diphtheria (a)	-	-	-	-	-	-	-	-	-	-
Donovanosis (a)	-	(b)	1	(b)	-	(b)	-	(b)	1	14
Giardiasis (a)	66	(b)	(b)	78	28	(b)	(b)	1	173	303
Genital herpes	87	(b)	133	(b)	(b)	(b)	1	2	223	443
Gonococcal ophthalmia neonatorum	-	-	-	-	(b)	(b)	-	(b)	-	1
Gonorrhoea (a)	43	-	93	35	57	1	13	2	244	572
Hepatitis A (infectious)	4	3	25	5	7	3	3	-	50	98
Hepatitis B (serum) (a)	46	5	29	2	29	6	2	5	124	287
Hepatitis - unspecified	-	(b)	2	-	(b)	(b)	-	-	2	3
Hydatid disease (a)	-	-	1	-	-	-	-	-	1	2
Lassa fever	-	-	-	-	-	-	-	-	-	-
Legionnaires disease (a)	3	1	1	-	-	(b)	-	(b)	5	15
Leprosy	3	-	(b)	-	-	-	-	-	3	5
Leptospirosis (a)	4	5	(b)	-	-	-	-	-	9	16
Lymphogranuloma venereum (a)	-	(b)	-	(b)	(b)	(b)	-	(b)	-	-
Malaria (a)	8	2	21	5	4	-	-	3	43	88
Marburg disease	-	-	-	-	-	-	-	-	-	-
Measles	3	(b)	7	-	-	(b)	(b)	-	10	24
Meningococcal infections (a)	4	2	-	-	-	(b)	1	-	7	20
Non-specific urethritis	113	(b)	(b)	(b)	(b)	(b)	4	(b)	117	277
Ornithosis (a)	-	-	-	-	-	-	-	-	-	1
Pertussis (whooping cough)	8	9	(b)	3	14	(b)	-	-	34	53
Plague	-	-	-	-	-	-	-	-	-	-
Poliomyelitis (a)	-	-	-	-	-	-	-	-	-	-
Q fever (a)	9	-	30	3	-	-	1	-	43	75
Rabies	-	(b)	-	-	-	(b)	-	(b)	-	-
Salmonella infections (a)	135	14	146	63	34	17	15	1	425	805
Shigella infections (a)	8	3	11	2	6	1	11	-	42	85
Smallpox	(b)	(b)	-	-	-	-	-	-	-	-
Syphilis (a)	26	-	38	7	7	(b)	11	1	90	251
Tetanus	-	-	(b)	-	-	-	-	-	-	-
Trachoma	-	(b)	(b)	3	-	(b)	(b)	-	3	248
Tuberculosis (all forms) (a)	49	15	13	24	7	1	1	1	111	199
Typhoid fever (a)	3	-	1	1	-	-	-	-	5	9
Typhus (all forms) (a)	-	-	-	-	-	-	-	-	-	1
Vibrio parahaemolyticus infections (a)	1	(b)	(b)	1	-	(b)	-	(b)	2	3
Yellow fever	-	-	-	-	-	-	-	-	-	-
Yersinia infections (a)	7	(b)	(b)	8	1	(b)	-	(b)	16	36

(a) Confirmed by appropriate diagnostic tests.
 (b) Not notifiable.

NOTIFIABLE DISEASES REPORTED IN AUSTRALIA

Period 3: 26 February 1989 - 25 March 1989

DISEASE	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	TOTAL	CUMULATIVE
										TOTAL
Amoebiasis (a)	-	1	-	2	1	-	-	1	5	15
Ankylostomiasis (a)	-	-	(b)	1	6	6	(b)	-	13	20
Anthrax (a)	-	-	-	-	-	-	-	-	-	-
Arbovirus infection (a)	57	15	253	19	130	2	3	-	479	1231
Brucellosis (a)	-	-	-	1	-	-	-	-	1	4
Campylobacter infection (a)	171	(b)	(b)	107	24	(b)	8	9	319	934
Chancroid (a)	-	-	-	(b)	-	(b)	-	(b)	-	-
Cholera	-	-	-	-	-	-	-	-	-	-
Congenital rubella syndrome	-	(b)	(b)	-	-	(b)	-	(b)	-	-
Diphtheria (a)	-	-	-	-	-	-	-	-	-	-
Donovanosis (a)	-	(b)	3	(b)	2	(b)	2	(b)	7	21
Giardiasis (a)	51	(b)	(b)	95	36	(b)	(b)	1	183	486
Genital herpes	19	(b)	119	(b)	(b)	(b)	-	-	138	581
Gonococcal ophthalmia neonatorum	-	-	-	-	(b)	(b)	1	(b)	1	2
Gonorrhoea (a)	71	-	82	-	45	3	16	1	218	790
Hepatitis A (infectious)	17	1	17	1	16	-	-	-	52	150
Hepatitis B (serum) (a)	30	10	48	5	36	2	1	-	132	419
Hepatitis - unspecified	1	(b)	3	1	(b)	(b)	-	-	5	8
Hydatid disease (a)	-	-	-	-	-	-	-	-	-	2
Lassa fever	-	-	-	-	-	-	-	-	-	-
Legionnaires disease (a)	5	2	2	1	3	(b)	-	(b)	13	28
Leprosy	-	-	1	-	-	-	-	-	1	6
Leptospirosis (a)	4	4	(b)	1	-	-	-	-	9	25
Lymphogranuloma venereum (a)	-	(b)	-	(b)	(b)	(b)	-	(b)	-	-
Malaria (a)	3	7	65	2	8	2	-	-	87	175
Marburg disease	-	-	-	-	-	-	-	-	-	-
Measles	-	(b)	7	2	-	(b)	(b)	-	9	33
Meningococcal infections (a)	2	2	-	1	1	(b)	2	-	8	28
Non-specific urethritis	90	(b)	(b)	(b)	(b)	(b)	2	(b)	92	369
Ornithosis (a)	1	-	-	-	-	-	-	-	1	2
Pertussis (whooping cough)	3	8	(b)	5	13	(b)	-	-	29	82
Plague	-	-	-	-	-	-	-	-	-	-
Poliomyelitis (a)	-	-	-	-	-	-	-	-	-	-
Q fever (a)	8	-	20	3	1	-	-	-	32	107
Rabies	-	(b)	-	-	-	(b)	-	(b)	-	-
Salmonella infections (a)	175	25	100	57	63	27	7	7	461	1266
Shigella infections (a)	4	3	7	4	14	1	7	1	41	126
Smallpox	(b)	(b)	-	-	-	-	-	-	-	-
Syphilis (a)	22	-	48	-	4	(b)	12	-	86	337
Tetanus	-	1	(b)	-	-	-	-	-	1	1
Trachoma	-	(b)	(b)	-	4	(b)	(b)	-	4	252
Tuberculosis (all forms) (a)	27	-	6	5	15	-	3	2	58	257
Typhoid fever (a)	5	1	-	-	-	-	-	-	6	15
Typhus (all forms) (a)	-	-	-	-	-	-	-	-	-	1
Vibrio parahaemolyticus infections (a)	-	(b)	(b)	-	-	(b)	-	(b)	-	3
Yellow fever	-	-	-	-	-	-	-	-	-	-
Yersinia infections (a)	7	(b)	(b)	15	1	(b)	-	(b)	23	59

(a) Confirmed by appropriate diagnostic tests.

(b) Not notifiable.