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Communicable Diseases Intelligence

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Editor Dr I.F. Cook

VIRUSES, CHLAMYDIAS, COXIELLAS, RICKETTSIAS AND MYCOPLASMAS REPORTING SCHEME: A total of 1760 reports were processed during this period.

Eighteen cases of Q fever (15 males, 3 females) were reported during this period. Ages ranged from 16 to 70 years. Occupational exposure details were available for 6 patients - 5 of whom were meatworkers.

Cytomegalovirus was isolated from:

- liver, lung, spleen and salivary glands tissue from a 24 week fetus with microcephaly; and
- liver, kidney and salivary gland tissue from a stillborn infant with intrauterine growth retardation and a chromosome 14 translocation abnormality. CMV had also been isolated from the amniotic fluid.

An early increase in influenza A activity has been observed this year compared 1987. In 1987 influenza A activity commenced in August and peaked in September (see figure next page). Forty percent of the 1988 cases have been in children under 5 years of age - 1987-1988.

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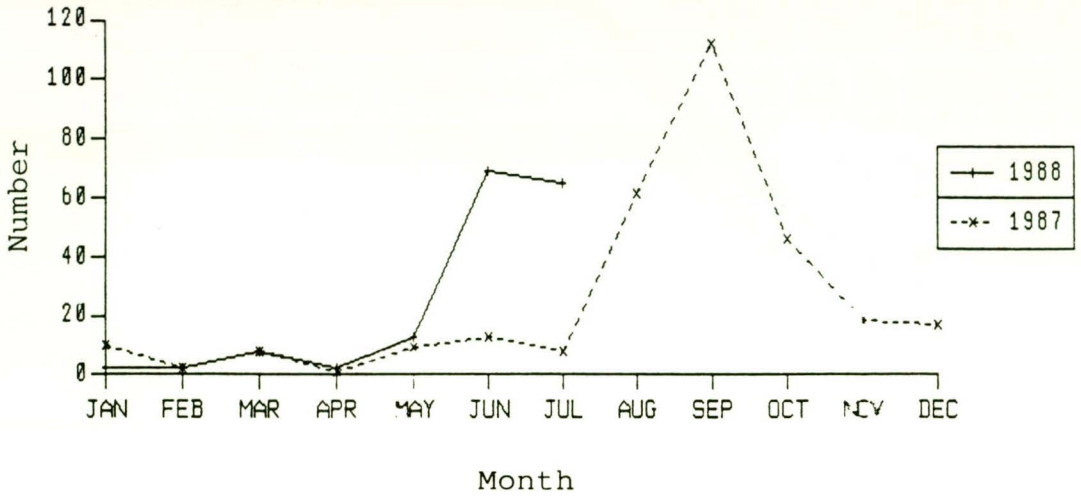
- Contributions are solicited, and do not preclude later publication elsewhere.
- Material appearing in the Bulletin may be quoted provided suitable acknowledgement is made.
- Figures given may be subject to revision.

Influenza A reports - CDI 1987 -1988



OVERSEAS BRIEF: PILGRIMAGE TO MECCA (HAJJ)

As previously advised in CDI 88/13, travellers to Mecca for the HAJJ season (from late July) must be in possession of a certificate of vaccination against meningococcal meningitis. The certificate must have been issued no more than 2 years and no less than 3 weeks before arrival in Saudi Arabia.

AIDS SURVEILLANCE - AUSTRALIA

To 11 July 1988, 914 cases of AIDS fulfilling the criteria of case definition have been reported to the National Health and Medical Research Unit in AIDS Epidemiology and Clinical Research. The distribution of those patients by State or Territory of notification (Table 1), by age group (Table 2), by risk category (Table 3) and by clinical presentation (Table 4) are shown below. As previously stated the clinical classification of infection with HIV produced by CDC in Atlanta was adopted in Australia on 1 January 1988. All reporting of clinical manifestations of HIV will now be presented using that classification.

TABLE 1: AIDS patients by State or Territory of notification

STATE/ TERRITORY	CASES			DEATHS		
	Male	Female	Total	Male	Female	Total
NSW	577	23	600	314	17	331
VIC	174	3	177	65	2	67
QLD	56	4	60	34	3	37
WA	37	2	39	16	1	17
SA	21	1	22	9	1	10
NT	2	0	2	1	0	1
TAS	2	1	3	2	0	2
ACT	11	0	11	5	0	5
	880	34	914	446	24	470

TABLE 2: AIDS patients by age group

AGE (YEARS)	CASES			DEATHS		
	Male	Female	Total	Male	Female	Total
0 - 9	8	2	10	6	1	7
10 - 19	5	1	6	3	1	4
20 - 29	192	8	200	95	2	97
30 - 39	380	3	383	182	1	183
40 - 49	213	4	217	105	4	109
50 - 59	65	6	71	43	6	49
60 +	17	10	27	12	9	21
	880	34	914	446	24	470

TABLE 3: AIDS patients by risk category

RISK GROUP	CASES	DEATHS
Homo-/Bi-sexual	802	398
IV drug user	6	2
Homo-/Bi-sexual IV drug user	24	14
Blood transfusion recipient	49	40
Person with haemophilia	12	6
Heterosexual transmission	8	2
Under investigation	7	3
None of the above	6	5
	914	470

TABLE 4: AIDS patients by clinical presentation

INITIAL DISEASE REPORTED	CASES	DEATHS
GROUP IV:		
B: Neurological disease	16	10
C: Secondary infectious diseases	665	338
D: Secondary cancers	181	90
E: Other conditions	2	1
BC: Neurological disease + infectious diseases	9	7
BD: Neurological disease + cancers	1	1
CD: Infectious diseases + cancers	40	23
	914	470

VICTORIAN HIV SURVEILLANCE PROGRAMME - 1987

(Based on the Victorian HIV Surveillance 1987 Annual Report, by SL Paine and B Monheit, AIDS Unit, Health Department of Victoria, March 1988, in conjunction with M Waters, M Dimitrakis, Fairfield Hospital, J Forsyth, R Darlington, Melbourne University, and V Sinickas, G Steele, Royal Melbourne Hospital.)

Testing for antibodies to HIV (Human Immunodeficiency Virus) became routinely available in Victoria in April 1985. In addition to the Blood Bank laboratories, laboratories at Fairfield Hospital, the Royal Melbourne Hospital and the Microbiological Diagnostic Unit (Melbourne University), were approved to carry out diagnostic tests for HIV in Victoria.

All samples which are positive by the ELISA test are sent to Fairfield Hospital confirmatory Western Blot testing or radioimmunoprecipitation assay. A uniform request form was devised to allow epidemiological surveillance of data[1].

The Victorian HIV Surveillance Programme was established by the three HIV antibody testing laboratories and the Health Department Victoria in 1986.

The aims of the program are to collate, analyse and disseminate aggregate information on the results of HIV antibody tests with particular emphasis on:

(i) monitoring the number of infected (HIV antibody positive) persons and trends over time by risk group, and

(ii) using the data to help evaluate AIDS programs and to help estimate further health-care requirements.

A brief report on HIV surveillance in Victoria, covering July 1985 to June 1986, has been published previously[2]. In addition a brief report on the effect of the April 1987 multi media advertising campaign (the 'Grim Reaper' campaign) has also been published[3].

This article summarises information from the 1987 Annual Report of the Victorian HIV Surveillance Programme. Readers are referred to the AIDS Unit, Health Department of Victoria for detailed data assessment.

Limitations of the data

The data collated in the HIV Surveillance Programme does not allow a correlation to be established between the number of tests performed and the number of persons tested, because of the difficulty in routinely determining the number of repeat tests. It is estimated that up to 20 per cent of tests may be repeats. However, positive results refer to individuals rather than tests.

The data is being continually updated and may be revised at a later date.

The reliability of the program in determining rates of HIV infection in the community and in special groups is limited by:

. the self-selecting nature of the population sample tested,

. the absence of acceptable estimates of the number of people tested in each group, and

. the lack of comparable denominator population estimates for various at risk groups.

Consequently meaningful analysis of trends may not be always possible because of these deficiencies.

Testing in 1987

During 1987, in addition to routine screening of blood donations, 51,746 ELISA tests were performed by the three

laboratories, and 352 new infected individuals were diagnosed as HIV antibody positive (data subject to revision):

	Number of tests	Number of new positive individuals diagnosed
. Homosexual/bisexual men	4,075	300
. Persons with haemophilia	311	8
. IV drug users	4,697	13
. Blood transfusion recipients	2,093	1
. Prostitutes	860	0
. Heterosexual contacts	4,149	10
. Screening of designated groups		
- Prisoners with no identified risk factors	2,167	0
identified risk factors	903*	6*
- IVF patients	1,313	0
- Renal dialysis patients	1,370	0
. Other (no specified risk factors, no identified risk factors, including screened individuals not belonging to above designated groups).	30,711	20

* These are included in the positive individuals with identified risk factors.

HIV infection attributed to **heterosexual contact** includes:

. 5 males;
- one who had heterosexual contact with a suspected IV drug user and prostitutes;
- one prisoner who had heterosexual contact with a prostitute
- three were heterosexually active but had no documented contact with any person in a high risk group or known to be infected with HIV.

. 5 females;
- one had heterosexual contact with an HIV antibody positive partner;
- three had had heterosexual contact with a partner in a high risk group; and
- one was heterosexually active but had no documented contact with any person in a high risk group or known to be infected with HIV.

Of the 20 HIV antibody positive cases **with no risk factor:**

. 1 female is being investigated for possible identified risk factors; and

. 19 males:
  - 11 are being investigated for possible identified risk factors;
  - one is from Uganda;
  - one is suspected of intravenous drug use because of past evidence of hepatitis B and delta agent infection; and
  - the five remaining cases had no further relevant information.
  - one has been identified through screening of military recruits.

Surveillance analysis

Risk factors for all HIV antibody positive persons diagnosed since testing began are shown in Table 1.

The total number of tests for HIV antibody has risen each year. However the identification of new antibody positive individuals has remained fairly constant over the past two years (see Table 1).

Table 1: Number of HIV antibody positive individuals diagnosed between 1984-1987#

Risk factor	Year				
	1984	1985	1986	1987	Total
Male homosexuality or bisexuality	465	373	308	300	1,446
Haemophilia	52	9	12	8	81
IV drug use	-	6	14	13	33
Blood transfusion	-	3	7	1	11
Prostitution	-	-	-	-	-
Heterosexual contact	-	1	-	10	11
Not specified	-	226*	24	20	270
Total positive	517	618	365	352	1,852
Total tested	2,879	19,906	25,120	51,746	99,651

This data is subject to revision

* Risk factors were not specified for nearly 37% of HIV and individuals diagnosed in 1985, as the uniform request form was not widely used at that time. Recent experience in following up infected people with no specified risk factor/s, has shown that a risk factors/s can be found in most instances.

The annual incidences of HIV infection among homosexual/bisexual men and IV drug users, as determined by this surveillance program has remained constant over the past two years. Other observations made on aggregated data collected since 1984 include:

. Out of 33 HIV positive **IV drug users:**

- 25 males: 4 aged 10-19 years
  16 aged 20-29 years.
  4 aged 30-39 years
  1 aged 40-49 years.
- 6 females: 2 aged 10-19 years
  3 aged 20-29 years.
  1 aged 30-39 years
- 2 with unknown gender and age

. Out of 23 HIV positive **females:**

- 6 were transfusion recipients
- 6 were IV drug users
- 8 had heterosexual contacts
- 1 was a Haitian child; and
- 2 have not specified any risk factors

For full evaluation of epidemiological data on HIV surveillance in Victoria, readers are requested to consult the 1987 Annual Report which also contains data on HIV testing at the Melbourne STD Clinic.

Routine HIV screening of blood donations

Four HIV antibody positive donors have been identified from 672,297 tests since routine screening of blood donors was introduced in Victoria in May 1985.

REFERENCES

1. CDI (1985) 85/13: 3-5.
2. CDI (1986) 86/24: 3-4.
3. CDI (1987) 87/17: 5-6.

MEASLES ELIMINATION BY 1990?

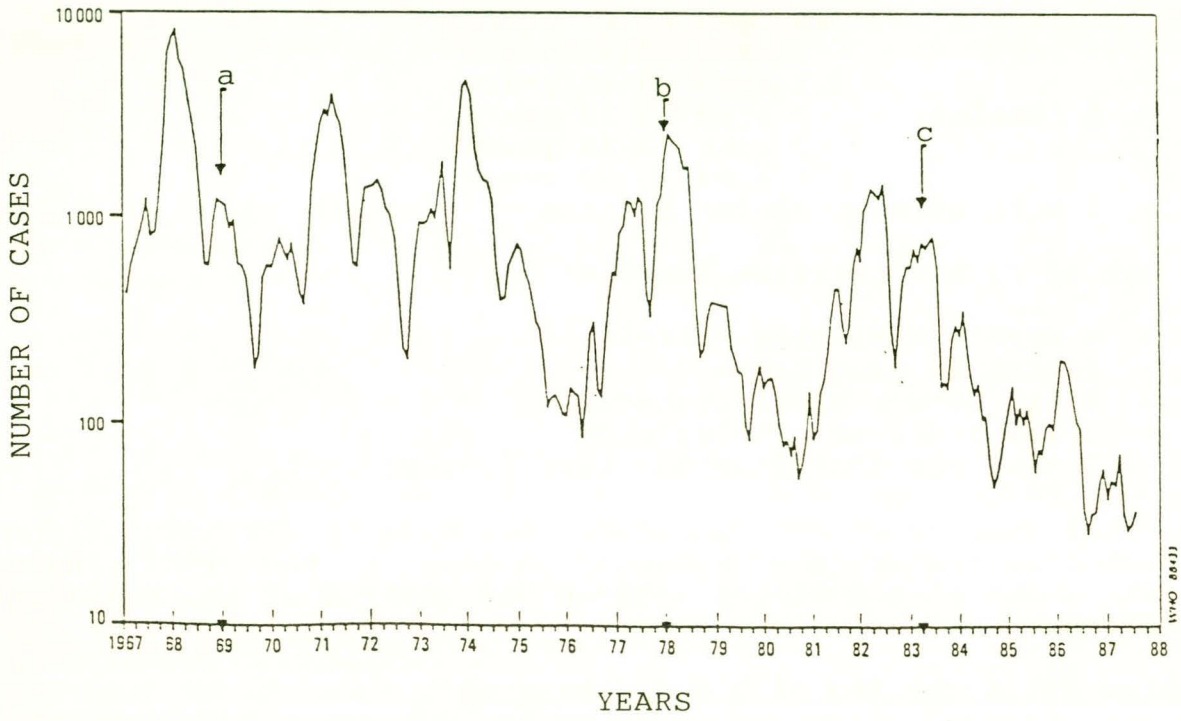
(Based on WER Vol 22, May 27 1988)

In Norway measles immunisation commenced in 1969 following a limited trial program in 1968. The vaccine was given initially 12 months of age and this was changed in 1978 to 15 months of age. Since 1983 the combined measles-mumps-rubella (MMR) vaccine has been used at 15 months and at 13 years. The goal of the present campaign in Norway is to eliminate indigenous measles by the end of 1990 as part of the WHO program for the elimination of measles in Europe.

To meet this goal a vaccine coverage of at least 95% (or preferably higher) must be achieved. The most recent coverage figures for Norway are from 1986 in which 3 counties have achieved coverages over 87% by the second birthday. The large number of vaccine doses distributed (134,720 for a target population of 110,000) also suggests a high level of immunisation activity in the country as a whole.

The immunisation program in Norway has resulted in a considerable decrease in the number of measles cases and an increase in the length of time between epidemics as shown in Figure 1.

Figure 1
Measles: notified cases, Norway, 1967-1987



a Measles vaccine introduced at 12 months of age.
b Measles vaccine changed to 15 months of age.
c MMR vaccine introduced at 15 months and 13 years of age.

For 1986 the reported incidence rate of measles in Norway was 30 per 100,000. This is a considerable improvement in comparison to previous years. The equivalent figure for 1987 is 12.6 per 100,000 based on reports for the first 8 months only. This achievement must be compared with results from other countries eg Sweden with an incidence of measles of 4 per 100,000 and the Netherlands with 0.16 per 100,000 in 1985.

The national incidence rate for Norway conceals the considerable local variations. In 1986 the incidence rates for individual counties varied from 6.7 per 100,000 in Oslo to 145 per 100,000 in Vest-Agder.

The number of deaths from measles dropped from 22 in the period 1966-71 to 6 in the period 1977-1981. There were 2 deaths in 1982 and 1 in 1985. Measles encephalitis, a complication that occurs in 0.5-1 per 1000 cases, has not been reported in Norway since 1982.

Norway has a catch up program in progress which aims to immunise persons born in 1968 or later (who have not been immunised) with either monovalent vaccine or MMR. Every health district is to ensure that all those eligible have been immunised.

Measles can be eliminated in Norway but it is essential to maintain a high immunisation coverage over the whole country. Experience has shown that where there are small pockets of unprotected individuals, outbreaks of measles occur sooner or later, often with a high average age of patients and thereby an increased risk of complications.

CDI Editorial Comment

Measles vaccine was introduced into Australia in 1968. In 1983 a survey found that only 68.4% of children aged 2-5 years had received measles vaccination (range 60.6 to 77.5%)[1]. In 1983 combined measles-mumps (MM) vaccine was introduced, this vaccine is administered to children at 12-15 months of age.

The low compliance of measles vaccination led the Australian Government to launch a National Campaign Against Measles (NCAM) in 1987. The main aim of this campaign is to increase measles vaccination coverage by increasing community awareness of the seriousness of the disease, encourage measles vaccination and to control measles by 1990 with eradication as soon as possible thereafter.

The Federal Government has provided $2 million(with $1.3 million allocated to the States and Territories) for promotional activities that would increase measles vaccine uptake.

The NCAM has led to an increase in MM vaccine uptake, though the rate of vaccine uptake differs between urban and rural areas. Generally in urban areas vaccine uptake is higher than in rural areas eg in South Australia, measles vaccine coverage in year 1 school children is 83% in metropolitan Adelaide and only 70% in some rural councils[2]. The campaign is now targetting rural areas to increase vaccination uptake in these areas. The evaluation of vaccine uptake has therefore identified the shortcomings of NCAM and has led in particular to the identification of areas with a low vaccine coverage, which will allow their targetting in the future.

Some States and Territories have also established catch up programs for older children who were not previously vaccinated.

The National Health and Medical Research Council (NH&MRC) have recommended (November 1987) that measles should be listed as a notifiable disease with notification based on strong clinical indications or serological diagnosis. This will enable a closer monitoring of the measles situation and aid in epidemic control.

REFERENCES

1. Children's Immunisation Survey, Australia, November 1983, Australian Bureau of Statistics.
2. NCAM 1987 Update, South Australian Health Commission.

GONOCOCCAL SURVEILLANCE - AUSTRALIA

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

This report provides details of penicillin sensitivity of 473 strains of gonococci isolated in participating laboratories over the period **1 January to 31 March 1987** (Table 1). The sensitivity of the isolates to penicillin was determined by a standardised technique[1] and the performance of each participant was monitored by an external quality assurance program.

Table 1 provides details of the percentage of strains in each mainland capital which fell into the categories of 'sensitive' or 'less sensitive' (see table footnotes) or which were penicillinase producers. Smaller numbers of isolates which did not fit into these categories are not included in the table.

A continuing decrease in the proportion of strains fully sensitive to penicillin was again noted. This increased level of intrinsic resistance has however not led to an increase in numbers of strains relatively resistant to penicillin (MIC 1.0 mg/L or greater) and organisms of this type are isolated infrequently.

The 94 PPNG isolates detected representing 16.2% of all isolates accounted for 16.6% of all strains examined. However significant regional differences were noted. PPNG accounted for nearly 40% of gonococci isolated in Sydney and 13.8% of all Melbourne isolates. This represents a significantly increased percentage of PPNG in Sydney whereas PPNG in Melbourne are less common than in the previous quarter[2]. For those patients in Sydney and Melbourne where details of contact were provided local acquisition of PPNG accounted for approximately half the cases of infection with this type of organism. In the other centres most infections with PPNG were acquired overseas.

Table 1: Penicillin sensitivity of isolates of N. gonorrhoea 1 January-31 March 1988

Centre	Percentage of isolates		
	Sensitive*	Less Sensitive**	PPNG
Brisbane	22.8 (20.2)	59.4 (62.3)	5.9 (10.9)
Sydney	8.4 (11.7)	40.8 (54.4)	38.8 (17.7)
Melbourne	4.8 (9.8)	50.0. (45.6)	13.8 (26.0)
Adelaide	18.0 (21.9)	67.5 (56.8)	4.8 (7.1)
Perth	20.6 (36.7)	47.0 (36.7)	9.7 (12.9)

* Sensitive MIC = 0.004-0.016 mg/L
** Less Sensitive MIC = 0.06-0.24 mg/L
Figures in parenthesis represent data for the same period in 1986.

In the last few AGSP reports comment has been made on the marked decrease in the number of gonococcal isolates. The number of isolates in this quarter (566) was a slight increase over the 473 strains examined in the previous quarter[2]. However there is always an increase in the incidence of gonorrhoea in warmer months. Further evidence of a decline in the rate of gonorrhoea in Australia can be found by noting that the number of isolates in this period is approximately half that reported in the corresponding period in 1987.

REFERENCES

1. Br J Vener Dis (1984) 60:226-30.
2. CDI (1988) 88/13: 14-15.

AIDS AND THE WORKPLACE: CONSENSUS STATEMENT FROM THE WHO CONSULTATION IN ASSOCIATION WITH THE INTERNATIONAL LABOUR ORGANISATION (ILO) GENEVA, 27-29 JUNE 1988

(Based on WER (1988) 63:217-19)

Introduction

HIV/AIDS in the workplace is on important issue since at any point in time, the majority of HIV infected persons are healthy and able to work. Over time, they may develop AIDS or other HIV-related conditions or they may remain healthy. It is estimated that approximately 90% of the 5-10 million HIV-infected persons worldwide are in the economically productive age-group. Therefore, it is natural that questions are asked about the implications of HIV/AIDS for the workplace.

Epidemiological studies form throughout the world have demonstrated that the human immunodeficiency virus (HIV) is transmitted only in the following ways:

- through sexual intercourse (including semen donation);
- through blood (principally blood transfusion and non-sterile injection equipment; also includes organ or tissue transplant);
- from infected mother to infant (perinatal transmission).

There is no evidence to suggest that HIV transmission involves insects, food, water, sneezing, coughing, toilets, urine, swimming pools, sweat, tears, shared eating and drinking utensils or other items such as protective clothing or telephones. There is no evidence to suggest that HIV can be transmitted by casual, person-to-person contact in any setting.

The purpose of the WHO Consensus Statement on AIDS and the Workplace, is to provide guidance for those considering issues raised by HIV/AIDS in the workplace, in the vast majority of occupations and occupational settings where work does not involve a risk of transmitting HIV between workers, from worker to client, or from client to worker.

Policy principles

Protection of the human rights and dignity of HIV-infected persons, including persons with AIDS, is essential to the prevention and control of HIV/AIDS. Workers with HIV infection who are healthy should be treated the same as any other worker. Workers with HIV-related illness, including AIDS, should be treated the same as any other worker with an illness.

Most people with HIV/AIDS want to continue working, which enhances their physical and mental well-being, and they should be entitled to do so. They should be enabled to contribute their creativity and productivity in a supportive occupational setting.

The World Health Assembly resolution (WHA-1.24) entitled, 'Avoidance of discrimination in relation to HIV-infected people and people with AIDS' urges Member States:

'(1) to foster a spirit of understanding and compassion for HIV-infected people and people with AIDS...;

(2) to protect the human rights and dignity of HIV-infected people and people with AIDS... and to avoid discriminatory action against, and stigmatisation of them in the provision of services, employment and travel;

(3) to ensure the confidentiality of HIV testing and to promote the availability of confidential counselling and other support services....'

The approach taken to HIV/AIDS and the workplace must take into account the existing social and legal context, as well as national health policies and the Global AIDS Strategy.

Policy development and implementation

Consistent policies and procedures should be developed at national and enterprise levels through consultations between workers, employers and their organisations, and where appropriate, governmental agencies and other organisations. It is recommended that such policies be developed and implemented before HIV-related questions arise in the workplace.

Policy development and implementation is a dynamic process, not a static event. Therefore, HIV/AIDS workplace policies should be:

- communicated to all concerned;
- continually reviewed in the light of epidemiological and other scientific information;
- monitored for their successful implementation; and
- evaluated for their effectiveness.

Policy components

A. Persons applying for employment:

Pre-employment HIV/AIDS screening as part of the assessment of fitness to work is unnecessary and should not be required. Screening of this kind refers to direct methods (HIV testing) or indirect methods (assessment of risk behaviours) or to questions about HIV tests already taken. Pre-employment HIV/AIDS screening for insurance or other purposes raises serious concerns about discrimination and merits close and further scrutiny.

B. Persons in employment:

1. HIV/AIDS screening: HIV/AIDS screening, whether direct (HIV testing), indirect (assessment of risk behaviours) or asking questions about tests already taken, should not be required.

2. Confidentiality: Confidentiality regarding all medical information, including HIV/AIDS status, must be maintained.

3. Informing the employer: There should be no obligation of the employee to inform the employer regarding his or her HIV/AIDS status.

4. Protection of employee: Persons in the workplace affected by, or perceived to be affected by HIV/AIDS, must be protected from stigmatisation and discrimination by co-workers, unions, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection.

5. Access to services for employees: Employees and their families should have access to information and educational programs on HIV/AIDS, as well as to relevant counselling and appropriate referral.

6. Benefits: HIV-infected employees should not be discriminated against nor denied standard social security benefits and occupationally related benefits.

7. Reasonable changes in working arrangements: HIV infection by itself is not associated with any limitation in fitness to work. If fitness to work is impaired by HIV-related illness, reasonable alternative working arrangements should be made.

8. Continuation of employment relationship: HIV infection is not a cause for termination of employment. As with many other illnesses, persons with HIV-related illnesses should be able to work as long as medically fit for available, appropriate work.

9. First aid: In any situation requiring first aid in the workplace, precautions need to be taken to reduce the risk of transmitting blood-borne infections, including hepatitis B. These standard precautions will be equally effective against HIV transmission.

Conclusion

By addressing the issues raised by HIV/AIDS and the workplace, workers, employers and governments will be able to contribute actively to local, national and international efforts to prevent and control AIDS.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

TOTAL VIRAL ISOLATIONS BASED ON DATE OF REPORTING
PERIOD - FORTNIGHTLY
VIRAL IDENTIFICATIONS FROM CONTRIBUTING LABORATORIES

Period 13-7-88 to 26-7-88.

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

		019	065	110	111	112	113	114	115	TOTAL
0100	ADENOVIRUS NOT TYPED	2	8	3	3	1	5	0	9	31
0101	ADENOVIRUS TYPE 1	1	1	0	0	0	0	0	0	2
0102	ADENOVIRUS TYPE 2	1	3	2	0	1	0	0	0	7
0103	ADENOVIRUS TYPE 3	0	2	1	0	0	0	0	0	3
0105	ADENOVIRUS TYPE 5	2	1	1	0	0	0	0	0	4
0107	ADENOVIRUS TYPE 7	0	0	1	0	0	0	0	0	1
0108	ADENOVIRUS TYPE 8	1	0	2	0	3	2	0	0	8
0109	ADENOVIRUS TYPE 9	0	1	0	0	0	0	0	0	1
0110	ADENOVIRUS TYPE 10	0	1	0	0	0	0	0	0	1
0114	ADENOVIRUS TYPE 14	0	1	0	0	0	1	0	0	2
0199	ADENOVIRUS TYPING PENDING	1	0	0	0	0	0	0	0	1
0201	INFLUENZA A VIRUS	1	31	6	7	5	6	2	1	59
0202	INFLUENZA A VIRUS SUBTYPE H3N2	3	0	0	0	4	0	4	0	11
0203	INFLUENZA B VIRUS	1	0	1	0	0	1	0	0	3
0206	INFLUENZA A H1N1	9	0	1	0	22	0	1	0	33
0301	PARAINFLUENZA VIRUS TYPE 1	2	3	5	1	0	0	2	2	15
0302	PARAINFLUENZA VIRUS TYPE 2	0	0	0	11	0	0	0	0	11
0303	PARAINFLUENZA VIRUS TYPE 3	1	0	18	3	1	0	0	5	28
0399	PARAINFLUENZA VIRUS TYPING PEN	0	0	0	0	0	0	0	3	3
0400	RESPIRATORY SYNCYTIAL VIRUS (R	41	10	51	64	11	12	7	53	249
0500	RHINOVIRUS (ALL TYPES)	3	1	1	1	0	2	0	3	11
0600	MYCOPLASMA PNEUMONIAE	19	3	18	6	2	3	3	12	66
0700	ORNITHOSIS-PSITTACOSIS	5	0	1	0	0	0	0	0	6
0800	COXSACKIEVIRUSES GROUP A - NOT	0	0	0	0	2	0	0	0	2
0809	COXSACKIEVIRUS A9	6	0	0	0	5	0	0	0	11
0816	COXSACKIEVIRUS A16	3	0	0	0	0	0	0	0	3
0821	COXSACKIEVIRUS A21	1	0	0	0	0	0	0	0	1
0899	COXSACKIEVIRUS GROUP A TYPING	1	0	0	0	0	0	0	0	1
0904	COXSACKIEVIRUS B4	0	0	1	0	0	0	0	0	1
0905	COXSACKIEVIRUS B5	2	1	0	0	1	0	0	0	4
1000	ECHOVIRUS NOT TYPED	0	3	0	0	0	0	0	0	3
1003	ECHOVIRUS TYPE 3	0	1	0	0	0	0	0	0	1
1004	ECHOVIRUS TYPE 4	0	0	1	0	0	0	0	0	1
1009	ECHOVIRUS TYPE 9	0	1	1	0	5	0	0	0	7
1011	ECHOVIRUS TYPE 11	0	0	1	0	0	0	0	0	1
1014	ECHOVIRUS TYPE 14	0	0	1	0	0	0	0	0	1
1022	ECHOVIRUS TYPE 22	1	0	0	0	0	0	0	0	1
1030	ECHOVIRUS TYPE 30	10	0	0	0	0	0	0	0	10
1100	POLIOVIRUS NOT TYPED	0	0	0	0	0	3	0	0	3
1101	POLIOVIRUS TYPE 1	2	4	0	0	0	0	0	0	6
1102	POLIOVIRUS TYPE 2	0	0	1	0	1	0	0	0	2
1103	POLIOVIRUS TYPE 3	0	1	0	0	0	0	0	0	1
1200	MUMPS VIRUS	0	2	0	1	0	1	0	2	6
1300	HERPES VIRUS GROUP - NOT TYPED	2	5	0	0	22	1	0	3	33
1301	HERPES SIMPLEX VIRUS - NOT TYP	4	2	0	0	0	0	0	1	7
1302	EPSTEIN-BARR VIRUS (EB VIRUS)	5	26	1	0	3	0	0	38	73
1303	VARICELLA-ZOSTER VIRUS	1	7	3	0	1	3	0	2	17
1306	HERPES SIMPLEX TYPE 1	44	52	16	0	25	0	0	25	162
1307	HERPES SIMPLEX TYPE 2	77	108	8	0	62	0	0	75	330
1399	HERPES VIRUS TYPING PENDING	4	1	0	2	0	0	0	0	7
1401	COXIELLA BURNETI	0	0	3	0	0	0	0	16	19
1402	OTHER RICKETTSIAE	0	0	0	0	0	0	0	1	1
1502	PICORNIA VIRUS - NOT TYPED = E	0	4	0	0	0	8	0	15	27
1521	MEASLES VIRUS	0	1	0	0	0	1	0	0	2
1522	RUBELLA VIRUS	2	2	0	0	0	0	0	4	8
1532	HEPATITIS B ANTIGEN	18	41	13	0	12	4	0	11	99
1535	HEPATITIS A ANTIBODY	0	20	4	0	0	0	0	0	24
1541	CHLAMYDIA A - C. TRACHOMATIS	9	36	4	1	8	0	0	17	75
1556	CMV - CYTOMEGALOVIRUS	28	8	4	1	3	0	0	40	84
1562	REOVIRUS (ALL TYPES)	0	0	0	0	2	0	0	0	2
1564	ROTAVIRUS	4	14	49	13	3	5	1	0	89
1599	ENTEROVIRUS TYPING PENDING	0	0	0	2	0	7	1	0	10
9992	ROSS RIVER VIRUS	3	1	0	0	0	0	0	56	60
9994	SMALL VIRUS (LIKE) PARTICLE	0	4	0	0	0	0	0	0	4
9998	ARBO. GROUP B. (UNSPECIFIED)	0	0	0	0	0	0	0	5	5
TOTAL		320	411	223	116	205	65	21	399	1760

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

VIRAL IDENTIFICATIONS BY CLINICAL INFORMATION TABLE 1.

Period 13-7-88 to 26-7-88.

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	8	0	0	0	18	0	0	0	0	27
0101	ADENOVIRUS TYPE 1	0	2	0	0	0	0	0	0	0	0	2
0102	ADENOVIRUS TYPE 2	1	2	0	0	0	4	0	0	0	0	7
0103	ADENOVIRUS TYPE 3	0	1	0	0	0	1	0	0	0	0	2
0105	ADENOVIRUS TYPE 5	0	3	0	0	0	1	0	0	0	0	4
0108	ADENOVIRUS TYPE 8	0	1	0	0	0	0	0	0	0	0	1
0114	ADENOVIRUS TYPE 14	0	0	0	0	0	1	0	0	0	0	1
0201	INFLUENZA A VIRUS	1	46	0	0	0	0	0	0	0	0	47
0202	INFLUENZA A VIRUS SUBTYPE H3N2	0	10	0	0	0	0	0	0	0	0	10
0206	INFLUENZA A H1N1	0	32	0	1	0	0	0	0	0	0	33
0301	PARAINFLUENZA VIRUS TYPE 1	0	14	0	0	0	0	0	0	0	0	14
0302	PARAINFLUENZA VIRUS TYPE 2	0	11	0	0	0	0	0	0	0	0	11
0303	PARAINFLUENZA VIRUS TYPE 3	0	28	0	0	0	0	0	0	0	0	28
0399	PARAINFLUENZA VIRUS TYPING PEN	0	3	0	0	0	0	0	0	0	0	3
0400	RESPIRATORY SYNCYTIAL VIRUS (R	1	240	0	1	0	0	0	0	0	2	244
0500	RHINOVIRUS (ALL TYPES)	1	10	0	0	0	0	0	0	0	0	11
0600	MYCOPLASMA PNEUMONIAE	9	41	0	0	0	0	0	0	0	0	50
0700	ORNITHOSIS-PSITTACOSIS	2	3	0	0	0	0	0	0	0	0	5
0800	COXSACKIEVIRUSES GROUP A - NOT	0	1	0	1	0	0	0	0	0	0	2
0809	COXSACKIEVIRUS A9	2	0	0	5	0	2	0	0	0	0	9
0816	COXSACKIEVIRUS A16	0	0	0	0	0	0	0	0	0	3	3
0899	COXSACKIEVIRUS GROUP A TYPING	0	0	0	1	0	0	0	0	0	0	1
0904	COXSACKIEVIRUS B4	0	1	0	0	0	0	0	0	0	0	1
0905	COXSACKIEVIRUS B5	0	0	0	3	0	1	0	0	0	0	4
1000	ECHOVIRUS NOT TYPED	0	1	0	0	0	2	0	0	0	0	3
1003	ECHOVIRUS TYPE 3	0	0	0	0	0	1	0	0	0	0	1
1004	ECHOVIRUS TYPE 4	1	0	0	0	0	0	0	0	0	0	1
1009	ECHOVIRUS TYPE 9	1	0	0	3	0	0	0	0	0	0	4
1011	ECHOVIRUS TYPE 11	0	1	0	0	0	0	0	0	0	0	1
1014	ECHOVIRUS TYPE 14	1	0	0	0	0	0	0	0	0	0	1
1022	ECHOVIRUS TYPE 22	0	1	0	0	0	0	0	0	0	0	1
1030	ECHOVIRUS TYPE 30	0	0	0	9	0	0	0	0	0	0	9
1100	POLIOVIRUS NOT TYPED	0	0	0	0	0	3	0	0	0	0	3
1101	POLIOVIRUS TYPE 1	0	2	0	0	0	3	1	0	0	0	6
1102	POLIOVIRUS TYPE 2	0	0	0	0	1	1	0	0	0	0	2
1103	POLIOVIRUS TYPE 3	0	0	0	0	0	1	0	0	0	0	1
1200	MUMPS VIRUS	1	1	1	1	0	0	0	0	0	0	4
1300	HERPES VIRUS GROUP - NOT TYPED	4	1	0	0	0	0	0	0	0	20	25
1301	HERPES SIMPLEX VIRUS - NOT TYP	0	0	0	0	0	0	1	0	0	0	1
1302	EPSTEIN-BARR VIRUS (EB VIRUS)	16	7	1	0	0	1	3	0	0	0	28
1303	VARICELLA-ZOSTER VIRUS	0	0	0	0	1	0	0	0	0	14	15
1306	HERPES SIMPLEX TYPE 1	3	12	1	0	0	0	0	0	0	69	85
1307	HERPES SIMPLEX TYPE 2	14	0	0	0	0	0	0	0	2	85	101
1399	HERPES VIRUS TYPING PENDING	0	0	1	0	0	0	0	0	1	2	4
1401	COXIELLA BURNETI	4	1	0	0	0	0	0	1	0	0	6
1502	PICORNIA VIRUS - NOT TYPED = E	1	7	0	0	3	13	0	0	0	2	26
1522	RUBELLA VIRUS	0	1	0	0	0	0	0	0	0	4	5
1532	HEPATITIS B ANTIGEN	54	1	0	0	0	0	24	0	1	0	80
1535	HEPATITIS A ANTIBODY	3	0	0	0	0	0	17	0	0	0	20
1541	CHLAMYDIA A - C. TRACHOMATIS	6	0	0	0	0	0	0	0	0	0	6
1556	CMV - CYTOMEGALOVIRUS	3	6	0	0	0	1	6	0	3	1	20
1562	REOVIRUS (ALL TYPES)	0	1	0	0	0	1	0	0	0	0	2
1564	ROTAVIRUS	0	0	0	0	0	89	0	0	0	0	89
1599	ENTEROVIRUS TYPING PENDING	1	3	0	1	0	5	0	0	0	0	10
9992	ROSS RIVER VIRUS	11	1	0	0	1	0	0	0	0	1	14
9994	SMALL VIRUS (LIKE) PARTICLE	0	0	0	0	0	4	0	0	0	0	4
9998	ARBO. GROUP B. (UNSPECIFIED)	2	0	0	0	0	0	0	0	0	0	2
TOTAL		144	504	4	26	6	153	52	1	7	203	1100

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

VIRAL IDENTIFICATIONS BY CLINICAL INFORMATION TABLE 2.

Period 13-7-88 to 26-7-88.

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

		12	13	14	15	16	17	18	19	20	21	TOTAL
0100	ADENOVIRUS NOT TYPED	0	0	0	0	0	0	0	2	2	0	4
0103	ADENOVIRUS TYPE 3	1	0	0	0	0	0	0	0	0	0	1
0107	ADENOVIRUS TYPE 7	1	0	0	0	0	0	0	0	0	0	1
0108	ADENOVIRUS TYPE 8	7	0	0	0	0	0	0	0	0	0	7
0109	ADENOVIRUS TYPE 9	0	0	0	0	0	0	0	1	0	0	1
0110	ADENOVIRUS TYPE 10	1	0	0	0	0	0	0	0	0	0	1
0114	ADENOVIRUS TYPE 14	0	0	0	0	0	0	0	1	0	0	1
0199	ADENOVIRUS TYPING PENDING	0	0	0	0	0	0	0	1	0	0	1
0201	INFLUENZA A VIRUS	0	0	0	0	0	0	3	6	2	1	12
0202	INFLUENZA A VIRUS SUBTYPE H3N2	0	0	0	0	0	0	0	1	0	0	1
0203	INFLUENZA B VIRUS	0	0	0	0	1	0	0	2	0	0	3
0301	PARAINFLUENZA VIRUS TYPE 1	0	0	0	1	0	0	0	0	0	0	1
0400	RESPIRATORY SYNCYTIAL VIRUS (R	0	0	0	0	0	0	1	1	1	2	5
0600	MYCOPLASMA PNEUMONIAE	1	0	0	1	0	0	1	10	3	0	16
0700	ORNITHOSIS-PSITTACOSIS	0	0	0	0	0	0	1	0	0	0	1
0809	COXSACKIEVIRUS A9	0	0	0	0	0	0	1	1	0	0	2
0821	COXSACKIEVIRUS A21	0	0	0	0	0	0	0	1	0	0	1
1009	ECHOVIRUS TYPE 9	0	0	0	0	0	0	0	2	0	1	3
1030	ECHOVIRUS TYPE 30	0	0	0	0	0	0	0	0	0	1	1
1200	MUMPS VIRUS	0	0	1	0	0	0	0	0	1	0	2
1300	HERPES VIRUS GROUP - NOT TYPED	2	5	0	0	0	0	0	0	1	0	8
1301	HERPES SIMPLEX VIRUS - NOT TYP	0	6	0	0	0	0	0	0	0	0	6
1302	EPSTEIN-BARR VIRUS (EB VIRUS)	0	0	6	5	1	0	2	25	6	0	45
1303	VARICELLA-ZOSTER VIRUS	1	0	0	0	0	0	0	0	1	0	2
1306	HERPES SIMPLEX TYPE 1	6	66	0	0	0	0	0	2	3	0	77
1307	HERPES SIMPLEX TYPE 2	0	228	0	0	0	0	0	1	0	0	229
1399	HERPES VIRUS TYPING PENDING	0	0	0	0	0	0	0	1	2	0	3
1401	COXIELLA BURNETI	0	0	0	1	0	0	0	9	3	0	13
1402	OTHER RICKETTSIAE	0	0	0	0	0	0	0	1	0	0	1
1502	PICORNIA VIRUS - NOT TYPED = E	0	0	0	0	0	0	0	1	0	0	1
1521	MEASLES VIRUS	0	0	0	1	0	0	0	0	1	0	2
1522	RUBELLA VIRUS	0	0	0	0	0	0	0	3	0	0	3
1532	HEPATITIS B ANTIGEN	0	0	0	0	0	0	0	0	19	0	19
1535	HEPATITIS A ANTIBODY	0	0	0	0	0	0	0	2	2	0	4
1541	CHLAMYDIA A - C. TRACHOMATIS	2	67	0	0	0	0	0	0	0	0	69
1556	CMV - CYTOMEGALOVIRUS	0	1	0	4	1	8	0	14	36	0	64
9992	ROSS RIVER VIRUS	0	0	0	0	32	0	0	7	7	0	46
9998	ARBO. GROUP B. (UNSPECIFIED)	0	0	0	0	0	0	0	3	0	0	3
TOTAL		22	373	7	13	35	8	9	98	90	5	660