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Communicable Diseases Intelligence

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Contents:

Editor Dr I.F. Cook

VIRUSES, CHLAMYDIAS, COXIELLAS, RICKETTSIAS AND MYCOPLASMAS REPORTING SCHEME: A total of 1,753 reports were processed during this period.

Twelve cases of Q fever, including 4 meatworkers, were reported during this period. There were two females aged 72 and 14 years and 10 males aged from 18 to 63 years.

Poliovirus type 2 was isolated from the faeces of a 2 year old male with bare lymphocyte syndrome. This child is a carrier of poliovirus type 2.

Adenovirus type 5 was isolated from lung, brain and digestive system postmortem samples of a male infant with sudden infant death syndrome.

Echovirus type 30 activity - Victoria

There is currently increased activity of echovirus type 30 in Victoria. Reports of isolates from 8 patients have been received during this period, making a total of 50 isolates from samples collected between April and August this year. Only one isolate has been reported from outside Victoria - from the State Health Laboratory Service in Perth. Approximately 85% of the reports this year have been associated with meningitis.

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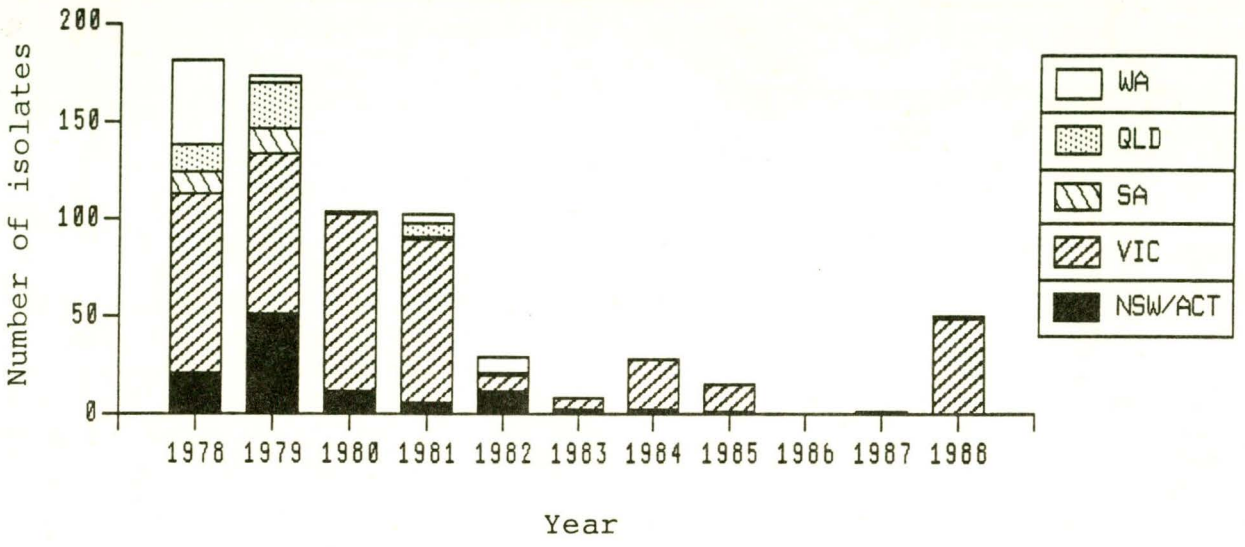
- Contributions are solicited, and do not preclude later publication elsewhere.
- Material appearing in the Bulletin may be quoted provided suitable acknowledgement is made.
- Figures given may be subject to revision.

The episodic character of echovirus type 30 infections in Australia over the last 11 years is shown in Figure 1.

Figure 1: Reports of echovirus type 30, CDI, 1978 - August 1988.



In a recent review of the epidemiology of viral meningeal syndromes in Alsace, France, for the years 1968-1987, echovirus type 30 accounted for 48% of viral isolates[1]. It was reported that the high incidence of echovirus type 30 was related to epidemics which occurred in the summers of 1968, 1975 and 1980. The highest attack rate was in children under 12 years of age with males accounting for more than two thirds of the cases.

The age break down for cases reported so far this year differs from the Alsace experience. Cases are spread over a wider age grouping (see table 1), although 70% of cases have been reported in males.

Table 1: Age distribution for echovirus type 30 isolates CDI, April - August 1988

Age	Number of Cases (%)
Less than 1 month	1 (2%)
1 - 11 months	4 (8%
1 - 4 years	6 (12%)
5 - 14 years	16 (32%)
15 - 24 years	5 (10%)
25 - 44 years	12 (24%)
Not known	7 (14%)

Reference

1.Rev Neurol (Paris) (1983) 139: 425-9.

INFLUENZA - UNITED STATES, 1987-88 SEASON
Based on MMWR (1988) 37: 497-504)

Influenza A(H3N2), the predominant type of influenza virus isolated in the United States during the 1987-88 season, exhibited antigenic drift from previous epidemic strains[1]. Many of the isolates resembled two strains first recognised in China during 1987, A/Sichuan/2/87 and A/Shanghai/11/87. Outbreaks reported during 1987-88 in the United States that were associated with these viruses occurred in all age groups, including residents of nursing homes. Antigenic variants of influenza B also circulated during the 1987-88 season, with most isolates resembling B/Victoria/2/87[2]. The number of influenza B virus isolates increased late in the season when the first outbreaks associated with this virus were reported; at the same time, influenza A(H3N2) declined. Influenza A(H1N1) viruses similar to A/Taiwan/1/86, the predominant influenza virus during the 1986-87 season[3], were least frequently isolated viruses during the 1987-88 season and were associated with only one possible outbreak, which occurred among college students. The number of influenza A(H1N1) virus isolates also increased late in the season.

Sources for surveillance of influenza were:

1. *State morbidity reports.* Each week, state and territorial epidemiologists estimated the extent of influenza-like activity indicated by surveillance systems in their state or territory by using the following categories: no cases; sporadically occurring cases; regional outbreaks (occurring in countries collectively consistituting less than 50% of the state's population); or widespread outbreaks (occurring in countries collectively constituting 50% or more of the state's population).

2. *Sentinel physician surveillance network.* CDC received weekly reports from 141 physician members of the American Academy of Family Physicians who recorded the number of patient visits for influenza-like illnesses. Reports were based on a clinical case definition, but some physicians submitted specimens to a central laboratory for diagnosis by rapid culture confirmation of influenza virus. A subgroup of 40 physicians collected nasopharyngeal specimens from selected cases and immediately submitted those specimens for virus processing. Rapid culture confirmation techniques were used to identify and report positive results to the physicians within 24 hours of test results or 5-6 days of specimen collection. The culture confirmation technique identified the type of influenza virus but not the subtype of influenza A.

3. *Mortality in 121 cities.* Death certificate data listing pneumonia or influenza (P&I) as a cause of death were reported from 121 cities weekly and analysed to determine if the percentage of deaths attributed to P&I was higher than would be expected in the absence of an influenza epidemic. This index has historically reflected seasonal influenza-attributable mortality[4].

4. *World Health Organization (WHO) collaborating laboratories.* Fifty-three laboratories, based in state or local health departments, universities, or hospitals, reported by postcard the number of specimens tested and the number and type of influenza viruses isolated for each week from early October through mid-May. Data from the other WHO collaborating laboratories were reported through the Epidemiologic Surveillance Project[5].

5. *Epidemiologic Surveillance Project (ESP).* In this project, case reports of culture confirmed influenza were submitted electronically to CDC from state health departments in Georgia, Kentucky, North Carolina, South Carolina, Texas and Vermont. All cases identified by WHO collaborating laboratories and other participating laboratories in these states were reported. Information reported for each case included patient age, country of residence, date of specimen collection, date of report to state, type of influenza virus identified, and, if known, the subtype for type A influenza viruses.

In addition to the methods described above, CDC received reports from military laboratories and Veterans Administration hospitals and reports of outbreaks and unusual influenza cases from a variety of sources.

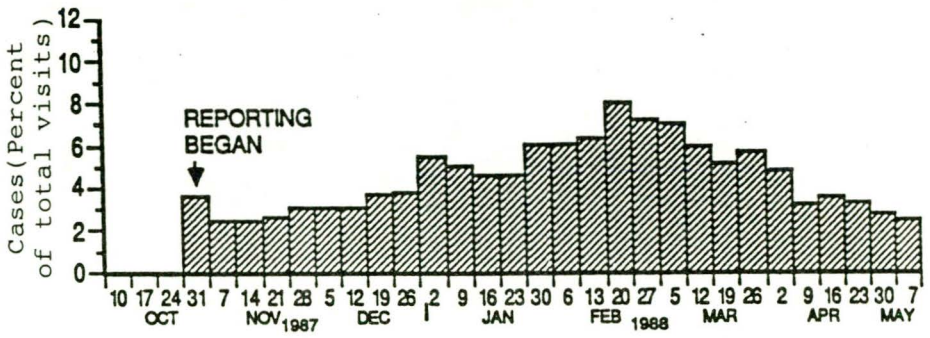
The first suspected outbreak of influenza A(H3N2) occurred in cruise ship passengers who were touring Alaska during August[6]. In October, a probable outbreak of influenza A(H3N2) occurred among American tourists travelling in the Orient aboard a cruise ship[7]. The first reported domestic outbreak of influenza-like illness occurred in November in preschool children in Colorado; influenza A(H3N2) was isolated from a specimen obtained from the index patient[8]. Sporadic isolates of influenza B were also reported early in the season from Arizona, Hawaii, and Wisconsin[9]. However, the first reported outbreak of influenza B occurred in February in a Connecticut nursing home. Most reported outbreaks of influenza A(H3N2) and influenza B occurred in nursing homes or other long-term-care settings.

According to reports by sentinel physicians, the mean percentage of total weekly patient visits associated with influenza-like illness was 4.8% (Figure 1). Sentinel physicians also reported each week whether an outbreak of influenza is occurring among their patients. Outbreaks were reported primarily during January and February by physicians in the western and central regions of the country and during February and March by physicians from the eastern regions.

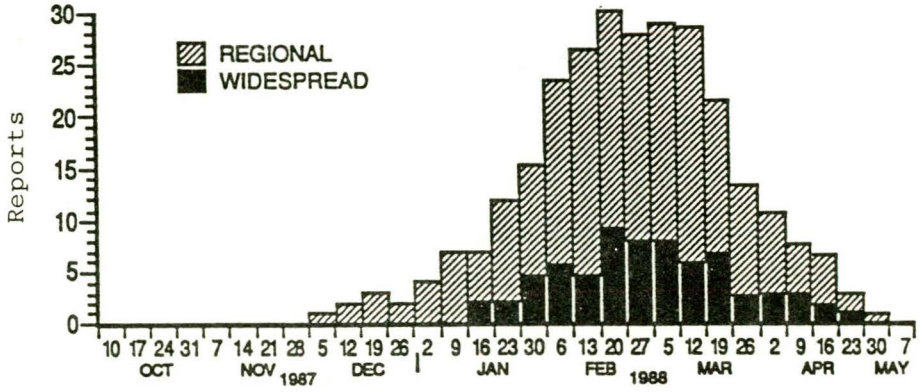
Morbidity reports from state epidemiologists indicated that peak influenza activity occurred during February and early March (Figure 1). Widespread or regional outbreaks were reported in 44 states and the District of Columbia. Outbreaks in the western and central regions of the country were reported earlier than those in the eastern regions.

Figure 1: Indicators of influenza activity, by week - United States, October 1987 - May 1988.

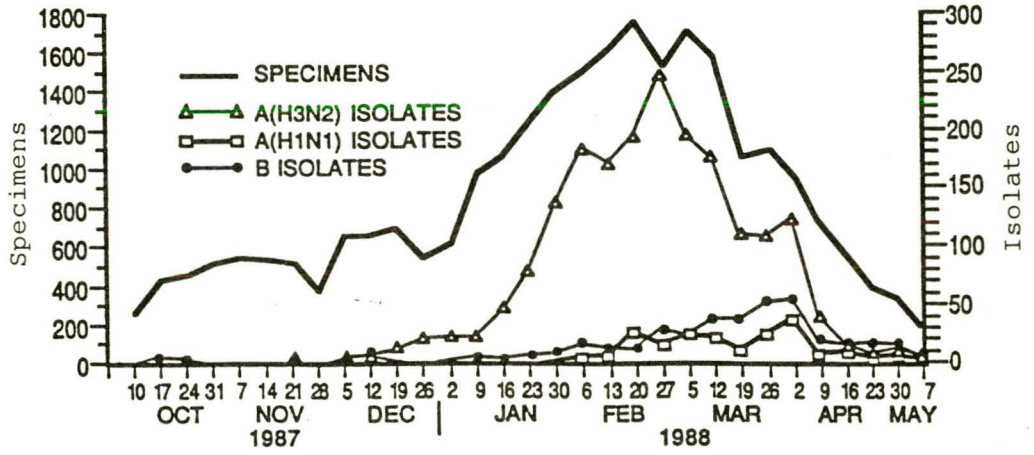
Influenza-like illness reported by sentinel physicians*



Outbreaks of influenza reported by state epidemiologists#



Isolations of influenza viruses**

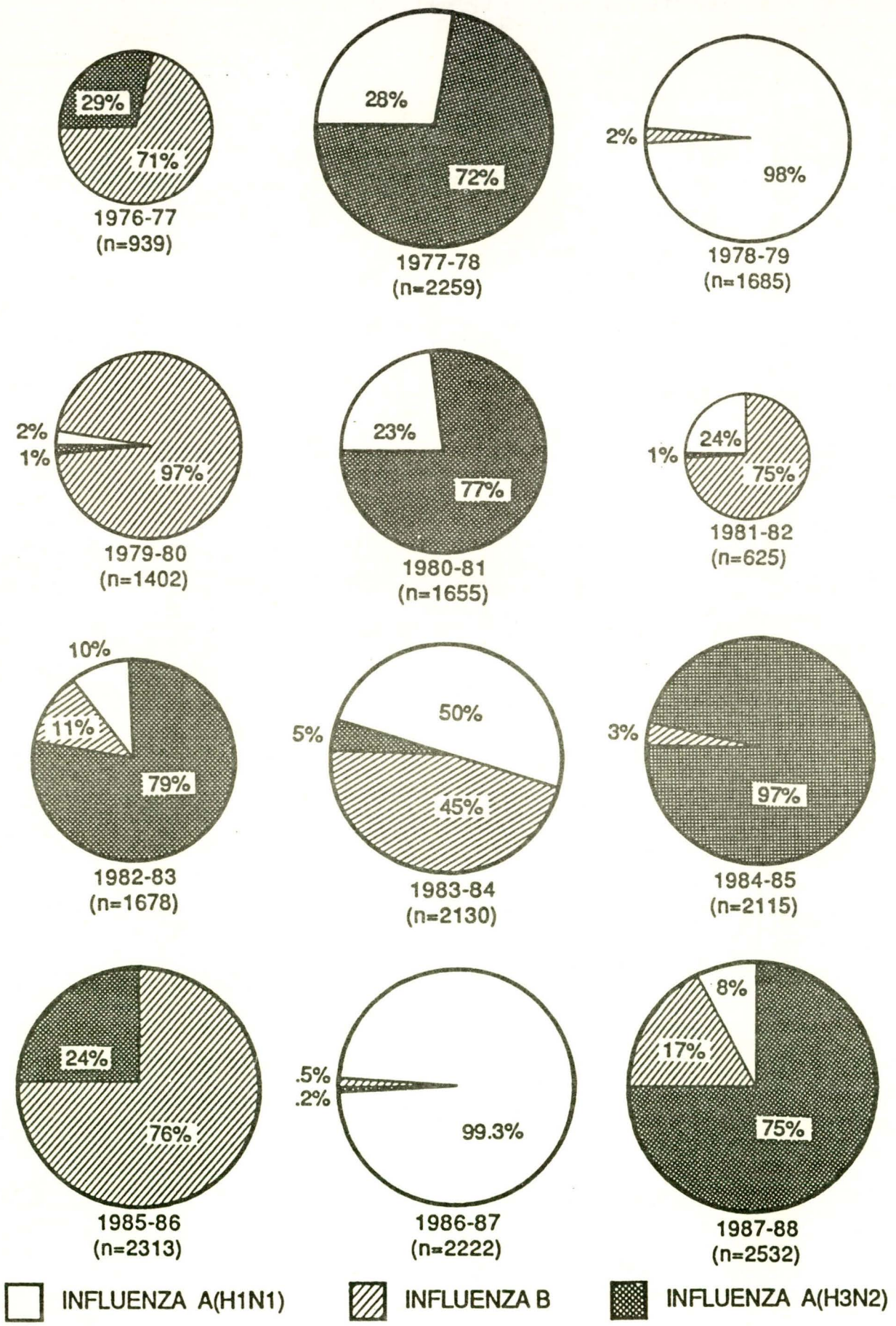


* Reported to CDC by 141 physician members of the American Academy of Family Physicians. A patient with a temperature 38.7°C(100°F) or higher and at least cough or sore throat was considered to have influenza-like illness.

Reported to CDC by state and territorial epidemiologists who used the following categories: no cases, sporadically occurring cases, regional outbreaks (occurring in countries collectively constituting less than 50% of the state's population), or widespread outbreaks (occurring in countries collectively constituting 50% or more of the state's population).

** Reported to CDC by 53 WHO collaborating laboratories (not including military laboratories).

Figure 2: Isolation of influenza viruses reported to CDC by collaborating laboratories - United States, 1976 - 1988



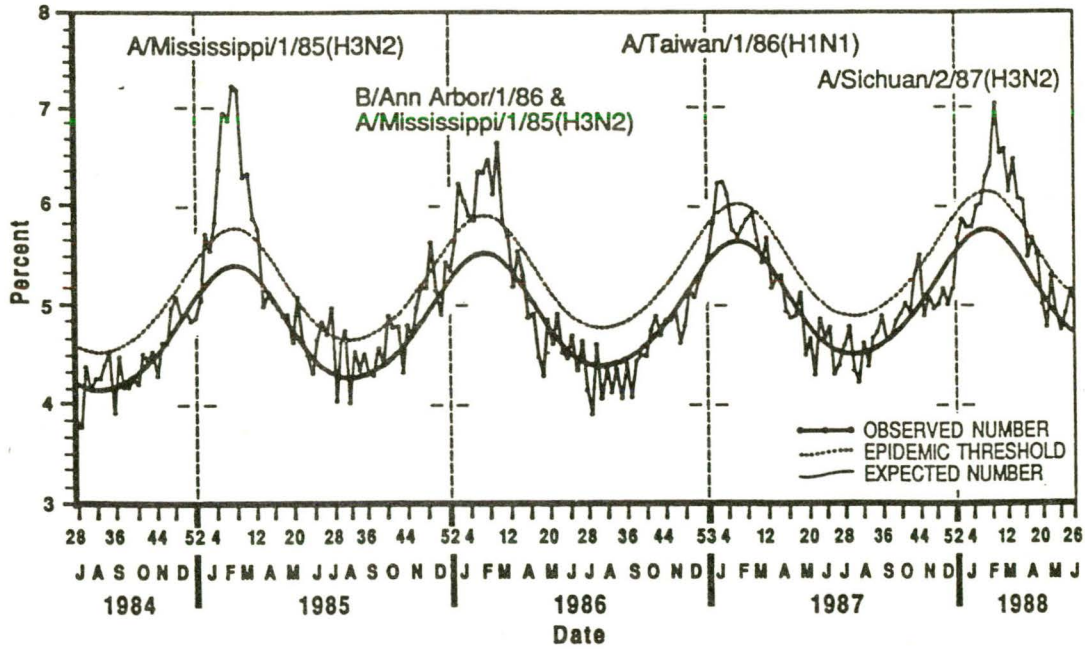
WHO collaborating laboratories tested 26,732 specimens for influenza viruses. Isolates were recovered from 2,532 (9.5%) of these specimens. Nineteen hundred (75%) of the isolates were influenza A(H3N2), 430 (17.0%) were influenza B, and 202 (8.0%) were influenza A(H1N1). [In 1986-87, 99.3% of influenza isolates were influenza A(H1N1).] (Figure 2).

Isolation of influenza A(H3N2) peaked during February, while influenza B and influenza A(H1N1) peaked during late March (Figure 1). Sentinel physicians submitted an additional 420 specimens for testing; 119 (28.3%) of these were positive for influenza viruses. Of the positive specimens, 110 (92.4%) were type A, and 9 (7.6%) were type B influenza.

Combining all laboratory reports, influenza A(H3N2) viruses were reported from 49 states and the District of Columbia; influenza B, from 26 states in all regions of the country and the District of Columbia; and influenza A(H1N1), from 19 states primarily in the eastern, central, and southern regions of the country.

The proportion of deaths associated with pneumonia and influenza (P&I) reported from 121 cities exceeded the epidemic threshold for 9 weeks, from the week ending 20 February through the week ending 16 April (Figure 3). Eighty-six per cent of the P&I) deaths reported occurred in persons 65 years of age or older. The 1987-88 season was the fifth year in the last decade that influenza A(H3N2) predominated. In each of the 5 years, excess mortality associated with P&I has occurred.

Figure 3: Pneumonia and influenza (P&I) deaths as a percentage of total deaths* - United States, July 1984 - June 1988.



Reported to CDC from 121 U.S. cities. P&I deaths include all deaths for which pneumonia is listed as a primary or underlying cause or for which influenza is listed on the death certificate. The predominant virus strain is shown above the peak of mortality for each epidemic season. The epidemic threshold for the 1987-88 influenza season was estimated at 1.645 standard deviations above the values projected on the basis of a periodic regression model applied to observed P&I deaths for the previous 5-year period but excluding the observations during influenza outbreaks.

Preliminary analysis of the data received through ESP indicates the relative proportions of influenza virus types reported through this system were similar to those reported on postcards by the other WHO collaborating laboratories. Of the 661 isolates reported through ESP, 508 (76.9%) were type A(H3N2), 94 (14.2%) were type B, 20 (3.0%) were type A(H1N1), and 39(5.9%) were type A viruses, not subtyped. Of the ESP isolate reports, 354 (53.6%) were reported from Harris County, Texas, where special influenza studies are conducted by the Influenza Research Center at the Baylor College of Medicine. The mean age of patients from whom isolates were recovered was 27 years for influenza A(H3N2), 20 years of influenza A(H1N1), and 19 years for influenza B. The median number of days between specimen collection and the date the results of virus testing were reported to the state epidemiologist was 27 days. Most reports were then transmitted to CDC within 1 week.

MMWR Editorial Note

During the 1986-87 season, influenza A(H1N1) was the most frequently isolated influenza virus. Since its reappearance in 1977, A(H1N1) has primarily been associated with morbidity in younger persons. In contrast, influenza A(H3N2) - the predominant strain during the 1987-88 season[3] - causes morbidity in all age groups and mortality in the elderly. In 1986-87, only 2.3% of all influenza isolates were from persons 65 years of age or older, while in 1987-88, 20.7% of the influenza A(H3N2) isolates reported by WHO collaborating laboratories reporting through the postcard system were from persons in this age group[3]. The excess mortality associated with P&I is consistent with an increased occurrence of influenza in the elderly (Figure 3).

The 1987-88 influenza epidemic was associated with strains that exhibited antigenic drift from the strain that had been included in the vaccine. However, because these variations were not recognised until the fall of 1987, the trivalent influenza vaccine could not be modified to include the new variant. As a result, the efficacy of the vaccine, at least in certain high-risk persons, may have been reduced.

Efforts to improve influenza control are emphasising rapid detection and reporting of influenza viruses - including those circulating in the Far East - in time to consider incorporating these viruses into the influenza vaccine. In addition, surveillance in the United States augmented by laboratory support enhances the monitoring of influenza, often before outbreaks occur, and can contribute to influenza control by enabling the use of antiviral agents in locations where influenza A is circulating.

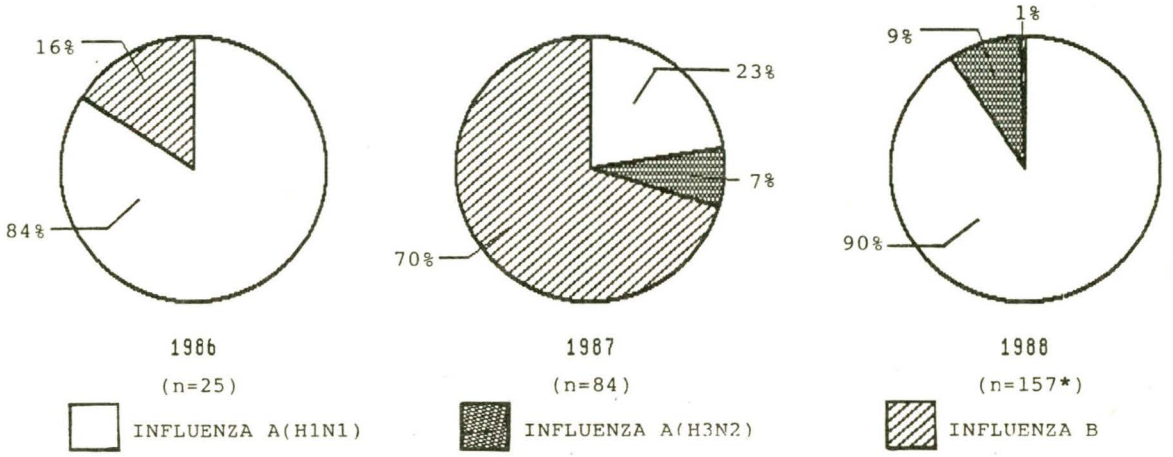
The ESP and Sentinel Physician Surveillance have expanded options for epidemiological surveillance of influenza. The ESP for influenza surveillance was first operated during the 1987-88 influenza season and provided data not reported by the postcard system. Specimen collection dates and additional case-specific information permit more detailed epidemiological analysis than the postcard reporting system, thereby enhancing surveillance of both morbidity and viral isolation. The results of the Sentinel Physician Surveillance Network, a pilot study in progress for several years, have demonstrated the

feasibility of a relatively inexpensive method for rapid confirmation of influenza in specimens collected by family physicians and have provided prompt feedback to these physicians[10].

CDI Editorial Comment

In contrast to the US experience, the 1988 influenza season in Australia has been dominated by influenza A(H1N1). As can be seen from Figure 4, 90% of influenza strains characterised by the WHO Influenza Reference Centre, Parkville, Victoria, have been influenza A(H1N1), with the remainder being influenza A(H3N2) (9%) and influenza B (1%).

Figure 4: Isolation of influenza viruses by WHO Influenza Reference Centre, Parkville, Victoria, 1986-1988.



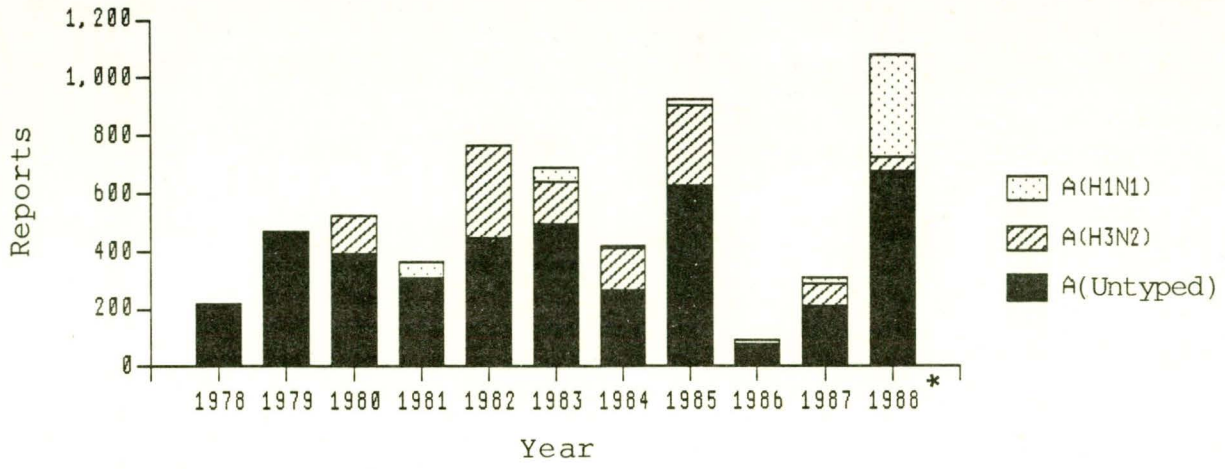
* Reports of influenza activity are still being received in Australia for the 1988 season, and this figure is not therefore expected to be the final number of isolates.

As previously stated most influenza A(H1N1) isolates resembled A/VIC/36/38. The predominating strain of influenza A(H3N2) characterised by the WHO Influenza Reference Centre most resembles A/VIC/7/87 although a small number of isolates resemble A/CHRISTCHURCH/2/88. The single isolate of influenza B characterised this year resembled B/VIC/2/87.[11]

It is interesting to note that the predominating subtype of influenza in New Zealand this season has been influenza A(H3N2) with only a small cluster of influenza A(H1N1) being reported late in the season[12].

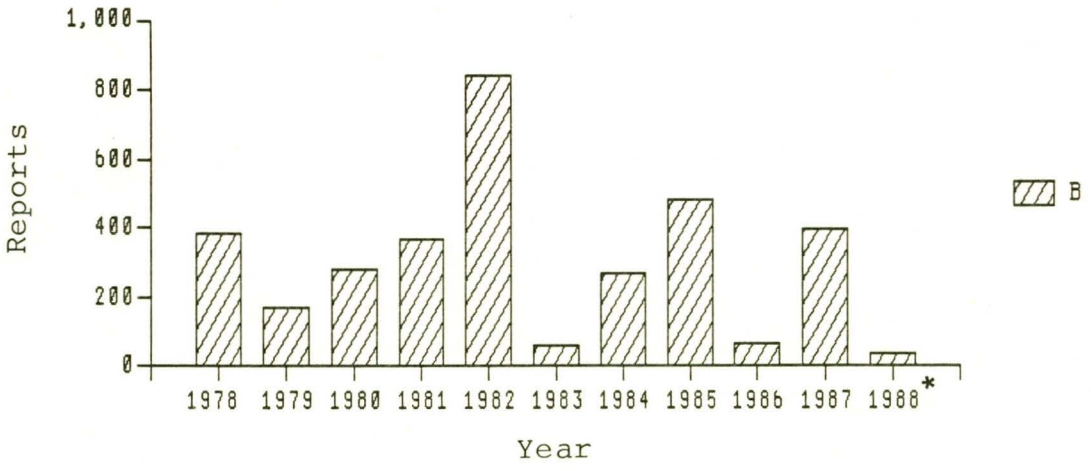
So far this year, 1,078 reports of influenza A (including 356 reports of subtype A(H1N1) and 48 reports of subtype A(H3N2)) and 38 reports of influenza B have been received through the CDI reporting scheme. This is the highest number of influenza A reported to CDI since 1978, although total influenza reports (including influenza B) have not reached the levels experienced in 1982 (1,607 reports) and 1985 (1,407 reports) when there were high levels of activity for both influenza A and influenza B. (Figures 5 & 6) (Note: Reports of influenza received through the CDI reporting scheme include serological diagnoses as well as isolations).

Figure 5: Influenza A reports, CDI reporting scheme, 1978 - September 1988



* NB. This does not cover a full year period.

Figure 6: Influenza B reports, CDI reporting scheme, 1978 - September 1988



* NB. This does not cover a full year period.

Reports of influenza activity continue to be received although at this stage only a small number of reports have been received for samples collected in September. Peak influenza A activity commenced in June this year; because of the lag time in reporting of cases it is too early to determine whether it will continue into September

REFERENCES

1. MMWR (1988) 37: 207-9.
2. MMWR (1988) 37: 241-4.
3. MMWR (1988) 37: 466-70,475.
4. Public Health Report (1988) 103: 120-8.
5. Am J Prev Med (1987) 3: 123-7.
6. MMWR (1987) 36: 697-8,704.
7. MMWR (1988) 37: 63-6.
8. MMWR (1988) 36: 820.
9. MMWR (1987) 36: 711-3.
10. J Clin Microbiol (1987) 25: 947-8.
11. CDI (1988) 88) 17:1
12. WER (1988) 63: 268.

'INFECTIOUS DISEASES IN EARLY CHILDHOOD SETTINGS: GUIDELINES FOR EARLY CHILDHOOD SERVICE PROVIDERS'

A new publication, *'Infectious diseases in early childhood settings: Guidelines for early childhood service providers'*, has been produced by the Communicable Disease Control Unit of the South Australian Health Commission, in conjunction with the Children's Services Office.

This book has been produced in response to concerns about infectious diseases in early childhood settings. Such concern is highlighted by the recognition that a significant number of children in early childhood settings may be infested with *Giardia lamblia,* a parasite which causes chronic diarrhoea, irritability and abdominal pain.

The book is in a loose-leaf A4 format allowing easy updating, and photocopying and distribution of information to staff and parents. It contains succinct sections on:

- disease transmission;
- preventive measures;
- food handling;
- nappy changing protocols; and
- individual diseases.

Information is provided on what is perceived as the 29 most significant infections affecting young children. These are:

- campylobacter.
- chicken pox
- common cold
- conjunctivitis
- cryptosporidiosis
- cytomegalovirus (CMV) infection
- giardiasis
- glandular fever (mononucleosis)
- hand, foot and mouth disease
- head lice (pediculosis capitis)
- hepatitis A (infectious hepatitis)
- hepatitis B
- human immunodeficiency virus infection (HIV, AIDS virus)
- impetigo (school sores)
- measles
- meningitis (bacterial)
- mumps
- ringworm/tinea
- rotavirus
- rubella (german measles)
- salmonella
- scabies
- shigella
- streptococcal sore throat 'strep'
- thrush
- tuberculosis (TB)
- viral gastroenteritis (viral diarrhoea)
- whooping cough (pertussis)
- worms

For each disease information is presented under the following headings:

- description of disease;
- incubation period;
- infectious period;
- responsibilities of parents and service providers;
- control of spread; and
- treatment.

The book also contains a poster on handwashing procedures and a flow chart illustrating an hygienic method of changing nappies.

It is available for $5.00 plus postage (unit weight 650 gms) from:

State Information Centre
25 Grenfell Street
Adelaide SA 5000
(Telephone: [08] 226.0000)

Enquiries should be directed to:

Communicable Diseases Control Unit
South Australian Health Commission
Box 6
Rundle Mall PO
ADELAIDE SA 5000
(Telephone: [08] 218.3445)

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

VIRAL IDENTIFICATIONS FROM CONTRIBUTING LABORATORIES
BASED ON DATE OF REPORTING

PERIOD 7-9-88 TO 19-9-88

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 PDN(NSW)
7. CODE 114 - RAHC(NSW)
8. CODE 115 - STATE LAB(QLD)

		019	065	110	111	112	113	114	115	TOTAL
0100	ADENOVIRUS NOT TYPED	0	7	17	4	4	2	0	7	41
0101	ADENOVIRUS TYPE 1	1	3	2	0	4	0	1	0	11
0102	ADENOVIRUS TYPE 2	0	0	0	6	16	0	0	0	22
0103	ADENOVIRUS TYPE 3	0	0	1	0	2	0	0	0	3
0104	ADENOVIRUS TYPE 4	1	0	0	0	0	0	0	0	1
0105	ADENOVIRUS TYPE 5	1	1	0	2	2	0	0	0	6
0106	ADENOVIRUS TYPE 6	0	1	0	0	0	0	0	0	1
0107	ADENOVIRUS TYPE 7	0	0	0	1	0	0	0	0	1
0122	ADENOVIRUS TYPE 22	0	0	0	0	1	0	0	0	1
0135	ADENOVIRUS TYPE 35	2	1	0	0	0	0	0	0	3
0199	ADENOVIRUS TYPING PENDING	0	0	1	3	0	1	0	0	5
0201	INFLUENZA A VIRUS	11	11	19	9	35	0	0	41	126
0202	INFLUENZA A VIRUS SUBTYPE H3N2	0	0	0	3	0	0	0	1	4
0203	INFLUENZA B VIRUS	0	0	0	0	0	0	1	1	2
0206	INFLUENZA A H1N1	13	0	34	0	0	0	0	6	53
0301	PARAINFLUENZA VIRUS TYPE 1	0	0	5	1	0	0	2	3	11
0302	PARAINFLUENZA VIRUS TYPE 2	0	0	4	0	0	0	0	0	4
0303	PARAINFLUENZA VIRUS TYPE 3	0	0	20	4	0	1	2	4	31
0400	RESPIRATORY SYNCYTIAL VIRUS (R	17	3	28	33	8	0	6	13	108
0500	RHINOVIRUS (ALL TYPES)	8	1	16	21	8	1	0	5	60
0600	MYCOPLASMA PNEUMONIAE	7	1	34	16	13	0	0	3	74
0700	ORNITHOSIS-PSITTACOSIS	2	0	0	0	3	0	0	0	5
0809	COXSACKIEVIRUS A9	0	0	0	8	3	0	0	0	11
0816	COXSACKIEVIRUS A16	2	0	0	0	0	0	0	0	2
0904	COXSACKIEVIRUS B4	0	0	0	1	0	0	0	0	1
0905	COXSACKIEVIRUS B5	1	1	0	0	1	0	0	0	3
0906	COXSACKIEVIRUS B6	1	0	0	0	0	0	0	0	1
1001	ECHOVIRUS TYPE 1	0	0	0	0	1	0	0	0	1
1004	ECHOVIRUS TYPE 4	0	0	1	0	0	0	0	0	1
1006	ECHOVIRUS TYPE 6	0	0	0	0	1	0	0	0	1
1009	ECHOVIRUS TYPE 9	0	2	0	0	3	0	0	0	5
1014	ECHOVIRUS TYPE 14	0	0	0	0	1	0	0	0	1
1022	ECHOVIRUS TYPE 22	1	0	0	0	1	0	0	0	2
1025	ECHOVIRUS TYPE 25	0	0	0	0	2	0	0	0	2
1030	ECHOVIRUS TYPE 30	5	0	0	3	0	0	0	0	8
1100	POLIOVIRUS NOT TYPED	0	0	0	9	0	0	0	0	9
1101	POLIOVIRUS TYPE 1	0	3	0	0	2	0	0	0	5
1102	POLIOVIRUS TYPE 2	0	0	0	0	1	0	1	0	2
1103	POLIOVIRUS TYPE 3	0	1	0	0	0	0	0	0	1
1200	MUMPS VIRUS	0	1	0	0	0	0	0	0	1
1300	HERPES VIRUS GROUP - NOT TYPED	0	2	0	0	16	0	0	2	20
1301	HERPES SIMPLEX VIRUS - NOT TYP	6	0	0	0	0	0	2	0	8
1302	EPSTEIN-BARR VIRUS (EB VIRUS)	5	15	3	1	6	0	3	8	41
1303	VARICELLA-ZOSTER VIRUS	3	4	2	0	4	0	0	1	14
1306	HERPES SIMPLEX TYPE 1	38	32	14	1	18	0	0	78	181
1307	HERPES SIMPLEX TYPE 2	66	73	7	0	75	0	0	118	339
1399	HERPES VIRUS TYPING PENDING	2	1	0	6	0	0	0	0	9
1401	COXIELLA BURNETI	0	0	0	0	1	0	0	11	12
1502	PICORNIA VIRUS - NOT TYPED = E	0	5	0	0	7	3	0	9	24
1521	MEASLES VIRUS	2	0	0	0	0	0	0	0	2
1522	RUBELLA VIRUS	5	1	1	0	3	0	0	4	14
1532	HEPATITIS B ANTIGEN	32	7	10	0	37	4	0	34	124
1535	HEPATITIS A ANTIBODY	5	4	1	0	1	0	0	0	11
1541	CHLAMYDIA A - C. TRACHOMATIS	14	21	7	0	24	0	0	16	82
1543	CHLAMYDIA A - LGV TYPE	0	0	0	0	1	0	0	0	1
1556	CMV - CYTOMEGALOVIRUS	15	3	3	9	10	4	2	24	70
1564	ROTAVIRUS	18	4	27	28	22	12	2	0	113
1566	NORWALK AGENT	0	0	0	0	1	0	0	0	1
1599	ENTEROVIRUS TYPING PENDING	0	0	0	22	0	5	0	0	27
9992	ROSS RIVER VIRUS	0	1	0	0	5	0	0	23	29
9994	SMALL VIRUS (LIKE) PARTICLE	0	0	0	0	0	0	1	0	1
TOTAL		284	210	257	191	343	33	23	412	1753

CORRECTION: Tables on the last pages of CDI 88/16 and 88/17 contained incorrect reports of one case of rabies (virus code 1552) in each issue. These are data entry errors and are cases of rubella (virus code 1522).

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

VIRAL IDENTIFICATIONS BY CLINICAL INFORMATION TABLE 1.

PERIOD 7-9-88 TO 19-9-88

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	4	6	7	8	9	10	11	TOTAL
0100	ADENOVIRUS NOT TYPED	3	20	0	0	14	0	0	0	0	37
0101	ADENOVIRUS TYPE 1	3	5	0	0	0	0	1	0	0	9
0102	ADENOVIRUS TYPE 2	4	9	0	0	4	0	0	0	1	18
0103	ADENOVIRUS TYPE 3	0	0	0	0	2	0	0	0	1	3
0105	ADENOVIRUS TYPE 5	0	3	0	0	0	0	0	0	0	3
0106	ADENOVIRUS TYPE 6	0	0	0	0	1	0	0	0	0	1
0135	ADENOVIRUS TYPE 35	0	0	0	0	0	0	0	1	0	1
0199	ADENOVIRUS TYPING PENDING	0	4	0	0	0	0	0	0	0	4
0201	INFLUENZA A VIRUS	19	76	0	2	0	1	0	0	0	98
0202	INFLUENZA A VIRUS SUBTYPE H3N2	0	4	0	0	0	0	0	0	0	4
0203	INFLUENZA B VIRUS	0	2	0	0	0	0	0	0	0	2
0206	INFLUENZA A H1N1	0	52	1	0	0	0	0	0	0	53
0301	PARAINFLUENZA VIRUS TYPE 1	0	11	0	0	0	0	0	0	0	11
0302	PARAINFLUENZA VIRUS TYPE 2	0	4	0	0	0	0	0	0	0	4
0303	PARAINFLUENZA VIRUS TYPE 3	0	31	0	0	0	0	0	0	0	31
0400	RESPIRATORY SYNCYTIAL VIRUS (R	2	105	0	0	0	0	0	0	0	107
0500	RHINOVIRUS (ALL TYPES)	3	53	0	1	0	0	0	0	0	57
0600	MYCOPLASMA PNEUMONIAE	3	59	0	0	0	0	0	0	0	62
0700	ORNITHOSIS-PSITTACOSIS	1	2	0	0	0	0	0	0	0	3
0809	COXSACKIEVIRUS A9	1	1	4	1	0	0	1	0	0	8
0816	COXSACKIEVIRUS A16	0	1	0	0	0	0	0	0	1	2
0904	COXSACKIEVIRUS B4	0	1	0	0	0	0	0	0	0	1
0905	COXSACKIEVIRUS B5	0	1	1	0	1	0	0	0	0	3
0906	COXSACKIEVIRUS B6	0	1	0	0	0	0	0	0	0	1
1001	ECHOVIRUS TYPE 1	0	0	0	0	1	0	0	0	0	1
1006	ECHOVIRUS TYPE 6	0	0	0	0	1	0	0	0	0	1
1009	ECHOVIRUS TYPE 9	2	1	1	0	1	0	0	0	0	5
1014	ECHOVIRUS TYPE 14	0	0	0	0	1	0	0	0	0	1
1022	ECHOVIRUS TYPE 22	1	0	0	0	0	0	0	0	0	1
1025	ECHOVIRUS TYPE 25	1	0	0	0	1	0	0	0	0	2
1030	ECHOVIRUS TYPE 30	0	1	6	0	0	0	0	0	1	8
1100	POLIOVIRUS NOT TYPED	0	4	0	0	0	0	0	0	1	5
1101	POLIOVIRUS TYPE 1	0	2	0	1	2	0	0	0	0	5
1102	POLIOVIRUS TYPE 2	0	0	0	0	1	0	0	0	0	1
1103	POLIOVIRUS TYPE 3	0	0	0	0	1	0	0	0	0	1
1300	HERPES VIRUS GROUP - NOT TYPED	6	2	0	0	0	0	0	0	10	18
1301	HERPES SIMPLEX VIRUS - NOT TYP	0	0	0	0	0	0	0	0	3	3
1302	EPSTEIN-BARR VIRUS (EB VIRUS)	14	1	0	0	1	2	0	0	0	18
1303	VARICELLA-ZOSTER VIRUS	3	0	0	2	0	0	0	0	9	14
1306	HERPES SIMPLEX TYPE 1	6	21	0	0	0	0	0	0	102	129
1307	HERPES SIMPLEX TYPE 2	16	2	0	0	0	0	0	0	90	108
1399	HERPES VIRUS TYPING PENDING	0	2	1	0	0	0	0	0	4	7
1401	COXIELLA BURNETI	1	1	0	0	0	0	0	0	0	2
1502	PICORNIA VIRUS - NOT TYPED = E	1	6	2	2	8	0	2	0	0	21
1521	MEASLES VIRUS	0	0	0	0	0	0	0	0	2	2
1522	RUBELLA VIRUS	0	0	0	0	0	0	0	0	10	10
1532	HEPATITIS B ANTIGEN	61	0	0	0	0	58	0	0	0	119
1535	HEPATITIS A ANTIBODY	6	0	0	0	0	3	0	0	0	9
1541	CHLAMYDIA A - C. TRACHOMATIS	16	0	0	0	0	0	0	0	0	16
1543	CHLAMYDIA A - LGV TYPE	0	1	0	0	0	0	0	0	0	1
1556	CMV - CYTOMEGALOVIRUS	7	23	0	3	0	5	0	7	1	46
1564	ROTAVIRUS	0	0	1	0	112	0	0	0	0	113
1566	NORWALK AGENT	0	0	0	0	1	0	0	0	0	1
1599	ENTEROVIRUS TYPING PENDING	0	11	4	0	3	0	0	0	0	18
9992	ROSS RIVER VIRUS	3	2	0	0	0	0	0	0	0	5
9994	SMALL VIRUS (LIKE) PARTICLE	0	0	0	0	1	0	0	0	0	1
TOTAL		183	525	21	12	157	69	4	8	236	1215

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

VIRAL IDENTIFICATIONS BY CLINICAL INFORMATION TABLE 2.

PERIOD 7-9-88 TO 19-9-88

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 - CONGENTIAL
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	2	0	0	0	0	0	0	0	2	0	4
0101	ADENOVIRUS TYPE 1	1	0	0	0	0	0	0	0	1	0	2
0102	ADENOVIRUS TYPE 2	0	0	0	0	0	0	1	0	2	1	4
0104	ADENOVIRUS TYPE 4	0	0	0	0	0	0	0	1	0	0	1
0105	ADENOVIRUS TYPE 5	0	0	0	0	0	0	0	0	1	2	3
0107	ADENOVIRUS TYPE 7	0	0	0	0	0	0	1	0	0	0	1
0122	ADENOVIRUS TYPE 22	1	0	0	0	0	0	0	0	0	0	1
0135	ADENOVIRUS TYPE 35	0	0	0	0	0	0	0	0	2	0	2
0199	ADENOVIRUS TYPING PENDING	1	0	0	0	0	0	0	0	0	0	1
0201	INFLUENZA A VIRUS	0	0	0	0	3	0	4	18	3	0	28
0400	RESPIRATORY SYNCYTIAL VIRUS (R	0	0	0	0	0	0	1	0	0	0	1
0500	RHINOVIRUS (ALL TYPES)	0	0	0	0	0	0	0	3	0	0	3
0600	MYCOPLASMA PNEUMONIAE	0	0	0	0	0	0	0	6	6	0	12
0700	ORNITHOSIS-PSITTACOSIS	0	0	0	0	0	0	2	0	0	0	2
0809	COXSACKIEVIRUS A9	0	0	0	0	0	1	1	0	1	0	3
1004	ECHOVIRUS TYPE 4	0	0	0	0	0	0	0	0	0	1	1
1022	ECHOVIRUS TYPE 22	0	0	0	0	0	0	0	0	0	1	1
1100	POLIOVIRUS NOT TYPED	0	0	0	0	0	0	0	0	1	3	4
1102	POLIOVIRUS TYPE 2	0	0	0	0	0	0	0	0	1	0	1
1200	MUMPS VIRUS	0	0	1	0	0	0	0	0	0	0	1
1300	HERPES VIRUS GROUP - NOT TYPED	0	2	0	0	0	0	0	0	0	0	2
1301	HERPES SIMPLEX VIRUS - NOT TYP	0	5	0	0	0	0	0	0	0	0	5
1302	EPSTEIN-BARR VIRUS (EB VIRUS)	0	0	2	7	3	0	0	4	7	0	23
1306	HERPES SIMPLEX TYPE 1	6	46	0	0	0	0	0	0	0	0	52
1307	HERPES SIMPLEX TYPE 2	0	230	0	0	0	1	0	0	0	0	231
1399	HERPES VIRUS TYPING PENDING	0	1	0	0	0	0	0	1	0	0	2
1401	COXIELLA BURNETI	0	0	0	1	1	0	0	7	1	0	10
1502	PICORNIA VIRUS - NOT TYPED = E	0	0	1	0	1	0	0	0	1	0	3
1522	RUBELLA VIRUS	0	0	1	0	0	0	0	2	1	0	4
1532	HEPATITIS B ANTIGEN	0	0	0	0	0	0	0	0	5	0	5
1535	HEPATITIS A ANTIBODY	0	0	0	0	0	0	0	0	2	0	2
1541	CHLAMYDIA A - C. TRACHOMATIS	1	65	0	0	0	0	0	0	0	0	66
1556	CMV - CYTOMEGALOVIRUS	0	0	0	2	0	0	0	6	16	0	24
1599	ENTEROVIRUS TYPING PENDING	0	0	0	1	0	0	0	5	0	3	9
9992	ROSS RIVER VIRUS	0	0	0	1	18	0	0	5	0	0	24
TOTAL		12	349	5	12	26	2	10	58	53	11	538