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Communicable Diseases Intelligence

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Contents:

VIRUS REPORTING SCHEME: A total of 1,378 reports were processed for this period.

Two cases of Q fever were reported, 1 from New South Wales and 1 from South Australia. No occupational exposure data was available for the reported cases. However none of the two patients was involved in the Q fever vaccine field trial conducted in South Australia.

Influenza B virus was isolated from:

- the nasal aspirate of 2 females, aged 83 and 78 and a 77 year old male during an influenza outbreak in a geriatric ward, and
- the post-mortem tissues derived from the lungs of a 17 year old female who died of atypical pneumonia.

Herpes simplex virus type 2 was isolated from:

- the nasal aspirate of a 2 year old male with Kawasaki disease,
- the saliva of a 58 year old female with pneumonia complicating renal failure, and
- the post-mortem tissues derived from the central nervous system of a 53 year old male with encephalitis of unknown aetiology.

Rhinovirus was isolated from the nasal aspirate of a 16 year old female bone marrow recipient who complained of myalgia and severe sore throat.

The Bulletin is compiled and distributed by the Communicable Diseases Branch, Department of Health, P.O. Box 100, Woden, A.C.T. 2606, Australia, and is available on request.
Contributions are solicited, and do not preclude later publication elsewhere.

Figures given may be subject to revision.

Poliovirus type 1 was isolated from the faeces of a 3 month old male who died of Sudden Infant Death Syndrome (SIDS).

AIDS SURVEILLANCE - AUSTRALIA

To 5 October 1987, 622 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) are shown below:-

TABLE 1: AIDS patients by State or Territory of Notification

STATE/ TERRITORY	CASES			DEATHS		
	Male	Female	Total	Male	Female	Total
NSW	413	16	429	227	14	241
VIC	101	1	102	45	1	46
QLD	39	3	42	29	2	31
WA	28	2	30	14	1	15
SA	10	1	11	2	1	3
NT	2	-	2	1	-	1
TAS	1	1	2	1	-	1
ACT	4	-	4	2	-	2
	598	24	622	321	19	340

TABLE 2: AIDS patients by age group

AGE (YEARS)	CASES			DEATHS		
	Male	Female	Total	Male	Female	Total
0 - 9	6	1	7	5	1	6
10 - 19	3	1	4	3	1	4
20 - 29	131	5	136	71	2	73
30 - 39	252	2	254	128	1	129
40 - 49	147	4	151	76	3	79
50 - 59	49	5	54	30	5	35
60 +	10	6	16	8	6	14
	598	24	622	321	19	340

TABLE 3: AIDS patients by risk category

RISK GROUP	CASES	DEATHS
Homo-/Bi-sexual men	545	286
IV drug users	3	2
Homo-/Bi-sexual IV drug user	19	10
Blood transfusion recipient	37	32
Person with haemophilia	6	4
Heterosexual transmission	5	1
Under investigation	1	-
None of the above	6	5
	622	340

AIDS UPDATE - INTERNATIONAL
(based on WER No. 36, 4 September 1987)

Global data - AIDS cases reported to WHO, by country, as of 2 September 1987

Country/Area	Date of report	Number of cases
Albania	31.08.87	–
Algeria	01.06.87	5
Angola	26.09.86	6
Anguilla	31.03.87	–
Antigua and Barbuda	31.03.87	2
Argentina	31.03.87	78
Australia	30.07.87	562
Austria	31.03.87	72
Bahamas	31.03.87	104
Bahrain	30.07.87	–
Bangladesh	14.04.87	–
Barbados	31.03.87	39
Belgium	31.03.87	230
Belize	31.03.87	2
Benin	18.05.87	3
Bermuda	30.06.87	60
Bhutan	14.04.87	–
Bolivia	30.06.86	1
Botswana	30.06.87	13
Brazil	30.04.87	1 695
British Virgin Islands	31.12.86	–
Bulgaria	12.08.87	2
Burkina Faso	13.11.86	–
Burma	14.04.87	–
Burundi	31.03.87	128
Cameroon	05.03.87	25
Canada	27.04.87	1 000
Cape Verde	30.04.87	4
Cayman Islands	31.12.86	2
Central African Republic	31.10.86	254
Chad	13.11.86	1
Chile	31.03.87	28
China	02.04.87	2
China (Province of Taiwan)	26.01.86	1
Colombia	31.03.87	57
Comoros	13.11.86	–
Congo	13.11.86	250
Costa Rica	31.12.86	20
Côte d'Ivoire	13.11.86	118
Cuba	31.12.86	3
Cyprus	01.06.87	3
Czechoslovakia	31.03.87	7
Democratic People's Republic of Korea	09.05.87	–
Denmark	31.03.87	150
Dominica	31.03.87	3
Dominican Republic	31.03.87	200
Eastern Mediterranean Region	23.08.87	24
Ecuador	31.03.87	18
Egypt	06.07.87	1
El Salvador	31.03.87	9
Ethiopia	30.06.87	5
Finland	31.03.87	19
France		
Metropolitan	30.06.87	1 964
Overseas:		
French Guiana	31.12.86	58
French Polynesia	01.04.87	1
Guadeloupe	31.12.86	40
Martinique	31.03.87	25
Reunion	10.06.87	1
Gabon	22.04.87	2
Gambia	16.03.87	14
German Democratic Republic	31.03.87	3
Germany, Federal Republic of	31.07.87	1 217
Ghana	25.05.87	145
Greece	31.03.87	41
Grenada	30.06.87	5
Guatemala	31.03.87	22
Guinea	30.06.87	9
Guinea Bissau	30.06.87	2
Guyana	31.12.86	2
Haiti	31.03.87	851
Honduras	31.03.87	20
Hong Kong	31.12.86	4
Hungary	31.03.87	3
Iceland	31.03.87	4
India	09.05.87	9
Indonesia	21.04.87	1
Ireland	31.03.87	19
Israel	31.03.87	38
Italy	30.06.87	850
Jamaica	11.05.87	16
Japan	16.06.87	43
Kenya	30.07.87	625
Lebanon	03.06.87	3
Lesotho	13.11.86	1
Liberia	12.06.87	2
Luxembourg	31.03.87	7
Madagascar	25.04.87	–
Malawi	13.11.86	13
Malaysia	01.04.87	1
Maldives	30.06.87	–
Malta	31.03.87	5
Mauritania	13.11.86	–
Mauritius	13.11.86	–
Mexico	31.03.87	407
Montserrat	31.12.85	–
Mozambique	30.06.87	1
Nepal	09.05.87	–
Netherlands	31.03.87	260
New Zealand	31.07.87	50
Nicaragua	31.12.86	–
Nigeria	22.05.87	5
Norway	31.03.87	45
Panama	31.03.87	14
Paraguay	31.03.87	10
Peru	30.06.86	9
Philippines	30.06.87	7
Poland	31.03.87	2
Portugal	31.03.87	54
Qatar	09.05.87	9
Republic of Korea	01.04.86	1
Romania	31.03.87	2
Rwanda	30.11.86	705
Saint Christopher and Nevis	31.12.86	1
Saint Lucia	31.12.86	3
Saint Vincent and the Grenadines	31.12.86	3
Sao Tomé and Principe	01.12.86	–
Senegal	13.11.86	–
Seychelles	13.11.86	–
Singapore	01.04.87	1
South Africa	24.07.87	77
Spain	31.03.87	357
Sri Lanka	14.04.87	2
Sudan	23.08.87	12
Suriname	31.03.87	3
Swaziland	01.07.87	7
Sweden	14.08.87	132
Switzerland	30.06.87	266
Thailand	30.06.87	11
Togo	13.11.86	–
Trinidad and Tobago	31.03.87	201
Tunisia	14.05.86	2
Turkey	30.06.87	21
Turks and Caicos Islands	31.12.86	2
Uganda	28.02.87	1 138
USSR	05.08.87	4
United Kingdom	31.07.87	935
United Republic of Tanzania	18.04.87	1 130
United States of America	24.08.87	40 845
Uruguay	31.12.86	8
Vanuatu	31.12.86	–
Venezuela	31.12.86	69
Yugoslavia	31.03.87	10
Zaire	30.06.87	335
Zambia	30.06.87	395
Zimbabwe	21.01.87	57
Total		**58 880**

HIV INFECTION AND PREGNANCIES IN SEXUAL PARTNERS OF HIV-SEROPOSITIVE HAEMOPHILIC MEN - UNITED STATES

(Based on MMWR Vol.36/No 35, 11 September 1985)

Seroprevalence rates for antibody to human immunodeficiency virus (HIV) have been reported in the United States to range from:-

- 33% to 92% for patients with haemophilia A, and
- 14% to 52% for those with haemophilia B[1-7].

The cumulative incidence of AIDS is currently estimated at:-

- 3% (345 cases) for US patients with haemophilia A, and
- 1% (23 cases) for those with haemophilia B.

The cumulative AIDS incidence for seropositive patients varies from region to region and is reported to be as high as 18% in one haemophilia treatment centre (HTC) in Pennsylvania[8]. Because sexual partners of infected men are also at risk of HIV infection[9, 10], the National Haemophilia Foundation (NHF) has developed extensive educational programs to inform patients with haemophilia and their sexual partners about the risk of HIV transmission.

The Division of Host Factors, Center for Infectious Diseases, Centers for Disease Control (CDC), and NHF conducted a survey of all U.S. HTCs and physicians known to treat patients with haemophilia. NHF estimates that those surveyed provide medical care for at least 75%of the haemophilic men in the United States. The purpose of the survey was to determine:-

1. whether sexual partners of known HIV seropositive haemophilic men were being tested for HIV antibody (the issue of counselling was not addressed),
2. the HIV seroprevalence rate among those partners who had been tested, and
3. the extent of compliance with NHF and Public Health Service recommendations for preventing sexual and perinatal transmission of HIV[11, 12].

Questionnaires were sent to 246 HTCs and physicians:

- 237 (96%) responded - either in writing (123)
  - or to follow-up telephone inquiries (114).
- 9 addressees (4%) - either could not be reached
  - or chose not to provide the requested information.

The 237 respondents provided information (Table 1) concerning 2,276 spouses/sexual partners of a comparable number of HIV seropositive haemophilic patients. (The vast majority of haemophilic men are reported to be monogamous. Respondents were not asked to indicate the number of HIV-seropositive haemophilic male partners represented by this survey.)

Table 1 HIV antibody testing of spouses/sexual partners of HIV seropositive haemophilic men , by pregnancy status of spouse/sexual partner - survey of US haemophilia treatment centres and physicians, 1987.

Test Results	Pregnancy Status: Pregnant No.	Pregnant (%)	Not pregnant No.	Not pregnant (%)	Total No.	Total (%)
Seropositive	22	8	55	3	77	3
Seronegative	148	53	547	27	695	31
Not tested*	110	39	1 394	70	1 504	66
Total	280	100	1 996	100	2 276	100

* Unknowns not included.

Seven hundred and seventy-two (34%) of the spouses/sexual partners were known to have been serologically tested for HIV antibody. Of those tested, 77 (10%) were reported to be seropositive. Among all spouses/sexual partners, 280 (12%) were reported to have been pregnant during the period January 1985 through March 1987.

One hundred and seventy (61%) of these women had been tested for HIV antibody; 22 (13%) of those tested were seropositive for HIV prior to pregnancy, during pregnancy, or at delivery. (Respondents were not asked to indicate at what stage during pregnancy testing was performed or why these women were tested for HIV antibody.) Six hundred and two (30%) non-pregnant spouses were tested; 55 (9%) were seropositive.

Twenty children had been born to these 22 seropositive women, two of whom were pregnant twice. One of these 24 pregnancies was therapeutically aborted, and the outcomes of three others were not reported.

Thirteen (65%) of the children born to HIV-seropositive women had been tested for HIV antibody-

. 4 (31%) were seronegative, and
. 9 (69%) were seropositive.

Because the infants' ages at the time of antibody testing were not given, it was not possible to determine whether the positive results reflect passively transferred maternal antibody or infection of the infant. None of the 20 children born to seropositive mothers have yet been diagnosed as having AIDS.

MMWR Editorial Note:

The reported rate of HIV seropositivity among spouses/sexual partners of seropositive haemophilic men in this survey is consistent with findings in earlier studies[9, 10]. However, there rates should not be generalised to all US haemophilic households because a number of limitations must be taken into account when interpreting the findings of this survey-

- The survey dealt only with spouses/sexual partners of known HIV-seropositive haemophilic patients. (NHF recommends voluntary HIV-antibody testing of haemophilic patients, along with appropriate pre-and post-test counselling.)
- A higher proportion of pregnant women than non-pregnant women had been tested (61% compared with 30%, $p<0.0001$). This finding suggests that some women may have been tested because they were pregnant or wished to become pregnant.
- HTCs and physicians have routine interaction with their haemophilic patients, but they may not interact as frequently or as closely with their patients' families or sexual partners. Therefore, HTCs and physicians may not be aware of the health status of their patients' family members/sexual partners. They may also be unaware of testing performed at other locations, eg. by obstetricians.

Abstention from sexual intercourse would eliminate any risk of sexual transmitted HIV infection [13]. The use of condoms, and possibly condoms in conjunction with spermicides, will reduce the risk of HIV transmission. However, even when condoms are properly used for each act of sexual intercourse, infected patients and their sexual partners should fully understand that some risk remains[14]. In accordance with Public Health Services guidelines health-care personnel should provide haemophilic patients and their sexual partners with thorough, confidential, and individualised counselling[12].

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HAEMOPHILUS INFLUENZAE TYPE B POLYSACCHARIDE VACCINE - PRELIMINARY POSTMARKETING SURVEILLANCE REPORT (U.S.A).

(Based on MMWR Vol.36/No.32, 21 August 1987)

In June 1987, the Immunisation Practices Advisory Committee (ACIP) reviewed preliminary postmarketing surveillance data presented at the April 1987, Food and Drug Administration (FDA) workshop on Haemophilus influenzae type b (Hib) polysaccharide vaccines. These data were evaluated in the light of the current ACIP recommendations for use of the vaccine(1) and for prophylaxis with rifampicin(2) in the prevention of invasive Hib disease.

In April 1985, the FDA licensed the first Haemophilus b polysaccharide vaccine. Two additional companies were licensed to produce similar vaccines at the end of 1985. Estimation of the efficacy of the vaccines was based on the results of a randomised, controlled clinical trial conducted in Finland. In that trial, which was conducted among children 18-71 months of age, efficacy was estimated to be 90%, with few serious adverse reactions reported(3). In addition, each manufacturer performed safety and immunogenicity studies before licensure. Upon licensure, the FDA asked each company to conduct postmarketing studies for rare adverse events in larger populations.

After licensure, the FDA, the Centers for Disease Control (CDC), the manufacturers, and individual investigators received spontaneous reports of invasive Haemophilus influenzae type b (Hib) disease in previously vaccinated children:

- One investigator published data suggesting that vaccine failure might be due to an inability to induce an appropriate antibody response(4).
- Several groups of investigators initiated studies to further evaluate the vaccine's efficacy.
- Investigators from
  - Northern Calfornia Kaiser Permanente Health Plan, and
  - the Minnesota Department of Health

  reported observing some cases of invasive Hib disease during the 1-week period immediately following vaccination.

These observations prompted the FDA to hold a workshop in April 1987, to discuss the ongoing studies of the vaccine's efficay. It was recognised that these studies were incomplete at the time of the meeting. The workshop was an open meeting involving experts in Haemophilus disease, epidemiology, and statistics.

Two issues were addressed:

- the efficacy of the vaccine and
- the interpretation of reports of invasive Hib disease in the 7 days following vaccination.

Investigators from
- the Northern California Kaiser Permanente Health Plan,
- Yale University and the University of Texas,
- the Minnesota Department of Health, and
- the Centers for Disease Control(CDC),

presented data. Each of these groups had been conducting studies for 2 years. Because of the normal delay in antibody formation following vaccination, the investigators had considered children to be vaccinated only if they had received vaccine 21 days or more (14 days or more in the CDC study) before the onset of disease. A brief synopsis of the data follows:

. The Kaiser group presented data from:
- a prospective cohort study which was not randomised and included about 122,000 children between 18 months and 5 years of age. There were 24 cases of invasive Hib disease in the unvaccinated group and two cases in the vaccinated group. The point estimate of the vaccine's efficacy was 89% (95% confidence interval: 52-97).
- a case-control study from this cohort yielded a point estimate of 81% (95% confidence interval: 10-96). Four children in this population developed disease within 7 days after vaccination. One of the patients had been immunised specifically because of exposure to Hib.

. Yale University and the University of Texas conducted a joint birth-certificate-matched case-control study among children 24 to 59 months of age. Investigators identified:
- 17 cases in Connecticut where 24% of the patients and 50% of the controls were vaccinated; and
- 25 cases in Dallas where 11% of the patients and 32% of the controls were vaccinated.

The point estimate of efficacy in Connecticut and Dallas was 89% (95% confidence interval: 69-97). In this study, one patient had been vaccinated within 7 days of the date of onset, and one control had been vaccinated within 7 days of the reference date, indicating no increased risk of Hib disease.

. The Minnesota Department of Health conducted a birth-certificate-matched case-control study among children 24 to 59 months of age. From September 1985 to March 1987, investigators identified 53 cases:
- 8 of the patients were excluded because of pre-existing risks for Hib disease (including immunodeficiency, sickle cell anaemia, or a previous episode of Hib disease).
- 15 (33%) of the 45 remaining patients were vaccinated, compared with 22 (24%) of the 90 controls.

The estimated protective efficacy was-86% (95% confidence interval: -415 to 33). The Minnesota investigators observed three cases of invasive Hib disease within 7 days of vaccination.

. CDC conducted a multistate day-care-based case-control study among children 18 to 59 months of age. There were 108 patients and 251 controls. Twenty (19%) of the patients and 73 (29%) of the controls had been vaccinated. The point estimate of efficacy was 44% (95% confidence interval: -5 to 70). Investigators identified four patients with onsets of invasive Hib disease during the first week vaccination; five controls had been vaccinated during a comparable interval.

Unlike these relatively small observational studies, the clinical trial of vaccine efficacy in Finland was a large, prospective, randomised trial involving over 48,000 recipients of Haemophilus b polysaccharide vaccine. This study is considered important because of its design and size. With the exception of the Minnesota study, and the efficacy studies presented at the April workshop, the results produced are not consistent with the results of the Finnish trial. However, since the more recent studies were observational, they may be subject to biases not usually found in randomised, controlled trials. These studies are continuing, and the data will be reassessed in the near future.

Although the Finnish study did not identify any cases of Hib disease within 7 days of vaccination, further information is necessary to evaluate the meaning of cases found soon after vaccination in the more recent studies. In any event, physicians should be aware that cases may occur in the week after vaccination, prior to onset of the protective effects of the vaccine.

While further analysis of these data is in progress, it was concluded that:

. based on evaluation of these preliminary data, the benefits of the vaccine continue to outweigh any potential risk. Therefore, physicians are urged to vaccinate their patients according to present ACIP recommendations;
. the preliminary data from these ongoing studies do not indicate a need for changes in the present ACIP recommendations for vaccine use. It should be emphasised that vaccination is not a substitute for prophylaxis with rifampin in children exposed to Hib disease;
. any adverse events, including vaccine failure, should be reported either to the manufacturer or to FDA.

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RESPIRATORY SYNCYTIAL VIRUS IN A PAEDIATRIC ONCOLOGY UNIT

(Contributed by B. Wild, G. O'Connor, J. Price and M. Willoughby, Princess Margaret Hospital for Children, Perth, Western Australia)

As part of an apparent epidemic of Respiratory Syncytial Virus (RSV) infection affecting Western Australia during the period from June to August 1987, the Princess Margaret Hospital for Children has reported an outbreak of RSV infection in its oncology ward.

CASE 1

A 16 month-old male, discharged after a normal chest x-ray confirming his good response to initial chemotherapy for acute lymphatic leukaemia, was re-admitted the following day with fever and tachypnoea. Empirical antibiotic therapy was initiated, fever gradually resolved, but the patient developed a moist cough 8 days later. RSV infection was demonstrated by indirect immunofluorescence (IF) examination of perinasal aspirate (PNA). Chest x-ray showed perihilar consolidation and the patient developed symptoms of acute respiratory distress. The patient's conditions improved rapidly on supportive therapy, but cough persisted for 2 weeks when a secondary bacterial infection was diagnosed and treated with oral erythromycin. RSV infection was still evident at 3, 4, 6 and 7 weeks post-treatment.

CASE 2

After 2 weeks of chemotherapy, a 2-year-old female with acute lymphatic leukaemia developed right upper lobe pneumonia which was treated with intravenous antibiotics. The patient subsequently developed inappropriate ADH syndrome - complicated by grand mal seizures.

A review, conducted one week later identified the patient and her younger sister to be colonised by RSV, however the patient appeared to be in full remission and was discharged 3 days following the review. She was re-admitted a week later with high fever and worsening cough. Chest x-ray showed increasing consolidation in the right upper lobe, and broad-spectrum antibiotic treatment for presumed bacterial infection was initiated.

RSV was isolated from the perinasal aspirate. The patient's clinical conditions and radiological chest signs deteriorated necessitating a bronchoscopy and open lung biopsy to be carried out within 48 hours of admission. RSV was again demonstrated by IF in biopsies from both right middle and lower lobes and from the bronchial aspirate. No other pathogens were identified. The patient's clinical condition continued to improve and a perinasal aspirate specimen taken one week following the biopsy was negative for RSV.

CASE 3

A 17 month-old female developed fever one week following her admission for the treatment of a very large abdominal neuroblastoma. The cause of fever was not determined and the patient was treated with broad-spectrum antibiotics. Chest x-ray taken 5 days after treatment commenced was normal.

A perinasal aspirate taken a week later yielded RSV and over the following week the patient developed a productive cough and intermittent fever. Chest x-ray taken at this stage showed bilateral peribronchial consolidation. The patient responded to antibiotics, and a perinasal aspirate taken one week post-treatment was negative for RSV and other pathogens.

CASE 4

A 3 and 1/2 year-old male was admitted with a bloody, purulent discharge from the right ear. Rhabdomyosarcoma was diagnosed and intensive chemotherapy and radiotherapy were commenced. A chest x-ray taken ten days following admission showed collapse of right upper and lower lobes with atelectasis and consolidation at the base. The patient failed to respond to a one-week empirical antibiotic treatment and was transferred to Intensive Care following evidence of an altered mental state and grand mal seizures associated with inappropriate ADH syndrome. Cotrimoxazole treatment was initiated for presumed Pneumocystis carinii infection because of progressive lung consolidation.

Despite vigorous treatment, pulmonary consolidation and general condition worsened and the patient died 3 weeks following transfer to Intensive Care. Extensive investigation of post-mortem tissues derived from the lungs only confirmed RSV infection.

COMMENT

The source of RSV infection in these patients has not been identified but could have been nocosomial:

- several ward staff were reported to have upper respiratory tract infections during the same period, but no laboratory investigations were undertaken;

- the oncology ward is open to contamination with frequent short admissions and discharges, ward transfers, and public visitors.

RSV morbidity has been well documented in:

- adults including hospital staff with up to 40% absenteism; and

. infants and young children with abnormalities of the respiratory and cardiovascular system. Respiratory illness is particularly severe in children undergoing chemotherapy in the oncology unit with patients harbouring RSV for an extended period of time, eg. up to 7 weeks in CASE 1.

The severity of RSV pathogenicity in the compromised host is well illustrated by the above cases. Clinicians are reminded that when RSV is prevalent, early identification of infected patients and health-care staff members is important and appropriate isolation precautions should be enforced to minimise risk to susceptible children.

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SALMONELLA ORANIENBURG AORTITIS - A CASE REPORT FROM WESTERN AUSTRALIA

(Contributed by C. Golledge and J.B. Iveson, Queen Elizabeth II Medical Centre).

Case Report

A 63 year old farmer who presented with diarrhoea, fever and abdominal pain was diagnosed as having acute cholecystitis. Cholecystectomy was performed and despite intravenous Amoxycillin and Metronidazole the patient remained febrile. S. oranienburg, sensitive to Amoxycillin was isolated from blood cultures.

An aortic aneurysm was noted during his initial admission and following its resection and the insertion of bilateral artero-femoral grafts, the patient made an uneventful recovery.

Comment

The source of infection in the above case has not been established but S. oranienburg has been frequently isolated from humans, animals and environmental sources.

Although ante-mortem diagnosis of salmonella aortitis is not frequent the number of diagnosed cases may be much higher than has been reported[1], with salmonella being isolated from up to 35% of infected aneurysms[2]. Mortality is minimised by surgical intervention, including in situ by pass[3, 4], and antibiotic treatment.

The risk of endothelial infection with salmonella bacteraemia has been estimated at 25% in patients older than 50 years of age[5]. Diagnosis of an aortic aneurysm in the elderly should therefore presume infectious aortitis until proven otherwise.

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AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD - 21-9-87 to 4-10-87 BULLETIN NUMBER 87/20
VIRAL IDENTIFICATIONS FROM CONTRIBUTING LABORATORIES

VIRUS OR VIRAL ANTIGEN	ICPMR (NSW)/ WVH (ACT)	RAHC (NSW)	PHH/ POW (NSW)	FAIR-FIELD (VIC)	RCH (VIC)	IMVS (SA)	STATE LAB (QLD)	STATE LAB (WA) *	Total
0100 ADENOVIRUS NOT TYPED	2		3		3	1	22	4	35
0101 ADENOVIRUS TYPE 1	1			2	10			1	14
0102 ADENOVIRUS TYPE 2	1			2	1	2			6
0103 ADENOVIRUS TYPE 3				3					3
0104 ADENOVIRUS TYPE 4					3				3
0105 ADENOVIRUS TYPE 5								1	1
0107 ADENOVIRUS TYPE 7	1								1
0110 ADENOVIRUS TYPE 10								1	1
0114 ADENOVIRUS TYPE 14								1	1
0199 ADENOVIRUS TYPING PENDING					1				1
0201 INFLUENZA A VIRUS	4	2		1		6		11	24
0202 INFLUENZA A VIRUS SUBTYPE H3N2				9	5	1			15
0203 INFLUENZA B VIRUS	13			9	5	11	12	9	59
0206 INFLUENZA A VIRUS SUBTYPE H1N1							1		1
0301 PARAINFLUENZA VIRUS TYPE 1				1			2		3
0302 PARAINFLUENZA VIRUS TYPE 2							1		1
0303 PARAINFLUENZA VIRUS TYPE 3	1	1		5	6	22	15	2	52
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	7	10		21	21	8	20	20	107
0500 RHINOVIRUS (ALL TYPES)	1			5	3	3	9	1	22
0600 MYCOPLASMA PNEUMONIAE	3				3	6		3	15
0700 ORNITHOSIS-PSITTACOSIS						1			1
0809 COXSACKIEVIRUS A9					4			1	5
0901 COXSACKIEVIRUS B1				2				1	3
0902 COXSACKIEVIRUS B2				3		1		1	5
0903 COXSACKIEVIRUS B3				1				4	5
0905 COXSACKIEVIRUS B5				2					2
1002 ECHOVIRUS TYPE 2				1					1
1014 ECHOVIRUS TYPE 14								2	2
1018 ECHOVIRUS TYPE 18				1	2			1	4
1020 ECHOVIRUS TYPE 20						2			2
1022 ECHOVIRUS TYPE 22			1	1		1		1	4
1100 POLIOVIRUS NOT TYPED			3		5				8
1101 POLIOVIRUS TYPE 1				3		1		3	7
1102 POLIOVIRUS TYPE 2				1					1
1200 MUMPS VIRUS								2	2
1300 HERPES VIRUS GROUP-NOT TYPED	11								11
1301 HERPES SIMPLEX VIRUS NOT-TYPED								4	4
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	16					5		4	25
1303 VARICELLA-ZOSTER VIRUS	1			1			1	5	8
1306 HERPES SIMPLEX TYPE 1	55		10	35		22	31	32	185
1307 HERPES SIMPLEX TYPE 2	98		26	67		26	52	33	302
1399 HERPES VIRUS TYPING PENDING					4				4
1401 COXIELLA BURNETI	1					1			2
1402 OTHER RICKETTSIAE	1								1
1502 PICORNA VIRUS-NOT TYPED	6		3				6	1	16
1522 RUBELLA VIRUS				4		2			6
1532 HEPATITIS B ANTIGEN	35	1	4	15		11	35	19	120
1535 HEPATITIS A ANTIBODY	5			1		2	1	8	17
1541 CHLAMYDIA A - C TRACHOMATIS	16			33	1		18	50	118
1556 CMV - CYTOMEGALOVIRUS	4	1	1	31	5	1	8	15	66
1564 ROTAVIRUS	16	5	4	12	6		2	18	63
1599 ENTEROVIRUS TYPING PENDING		5	4		3				12
9992 ROSS RIVER VIRUS								1	1
Total	299	25	59	272	91	136	236	260	1,378

* Including 60 reports from Princess Margaret Hospital for Children

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 21-9-87 to 4-10-87 BULLETIN NO 87/20

Viral Identifications by Clinical Information Table 1.
Code 00,99 -No ill or data; 01,02,11,12 -Respiratory; E3 -Encephalitis; M3 -Meningitis; 04 -Paralysis; 05,13 -CNS other unspec.; 07,49 -GI; 17,47 -Hepatic; 19 -CVS; 89 -Urinary; 06 -Skin/mucous.

VIRUS OR VIRAL ANTIGEN	No-ill or data	Respir -atory	Enceph -alitis	Mening -itis	Para- lysis	CNS other unspec	GI	Hepa -tic	CVS	Urin -ary	Skin/ mucs memb
0101 ADENOVIRUS TYPE 1.....		9					2				1
0102 ADENOVIRUS TYPE 2.....		4				1					
0103 ADENOVIRUS TYPE 3.....		3									
0104 ADENOVIRUS TYPE 4.....		1									
0105 ADENOVIRUS TYPE 5.....		2									
0107 ADENOVIRUS TYPE 7.....		1									
0201 INFLUENZA A VIRUS.....		18				1					
0202 INFLUENZA A VIRUS SUBTYPE H3N2		12					1				
0203 INFLUENZA B VIRUS.....	3	37				3	2		1		2
0206 INFLUENZA A VIRUS SUBTYPE H1N1		1									
0301 PARAINFLUENZA VIRUS TYPE 1....		3									1
0302 PARAINFLUENZA VIRUS TYPE 2....		1									
0303 PARAINFLUENZA VIRUS TYPE 3....		51		1							
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....	1	102		1							
0500 RHINOVIRUS (ALL TYPES).....		6		1							
0600 MYCOPLASMA PNEUMONIAE.....	4	9									1
0700 ORNITHOSIS-PSITTACOSIS.....		1									
0809 COXSACKIEVIRUS A9.....				3							
0901 COXSACKIEVIRUS B1.....			1				2				
0902 COXSACKIEVIRUS B2.....		5									
0903 COXSACKIEVIRUS B3.....				2							
0905 COXSACKIEVIRUS B5.....		1							1		
1014 ECHOVIRUS TYPE 14.....		1					2				
1018 ECHOVIRUS TYPE 18.....				1							1
1020 ECHOVIRUS TYPE 20.....	1	1									
1022 ECHOVIRUS TYPE 22.....		4									
1101 POLIOVIRUS TYPE 1.....		2					2				
1102 POLIOVIRUS TYPE 2.....		1									
1200 MUMPS VIRUS.....	1			1							
1300 HERPES VIRUS GROUP-NOT TYPED..											3
1301 HERPES SIMPLEX VIRUS NOT-TYPED											4
1302 EPSTEIN-BARR VIRUS (EB VIRUS).	4	2				1		7			
1303 VARICELLA-ZOSTER VIRUS.....			1		1						5
1306 HERPES SIMPLEX TYPE 1.....	5	8	1	1				1	1	1	99
1307 HERPES SIMPLEX TYPE 2.....	15	4									56
1401 COXIELLA BURNETI.....		1									
1402 OTHER RICKETTSIAE.....	1										
1522 RUBELLA VIRUS.....											4
1532 HEPATITIS B ANTIGEN.....	52	1						60			1
1535 HEPATITIS A ANTIBODY.....	6							9			
1541 CHLAMYDIA A - C.TRACHOMATIS...	7										1
1556 CMV - CYTOMEGALOVIRUS.....	5	23					3	2		4	4
1564 ROTAVIRUS.....	1	1					62				
Total.....	106	316	3	11	1	6	76	79	3	5	183

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 21-9-87 to 4-10-87 BULLETIN NO 87/20
Viral Identifications by Clinical Information Table 2.
Code 10 -Eye; 59 -Genital; 39 -Endo/sal gland;
38 -RES; 29 -Muscle/joint; 69 -Congenital; P8 -PUO;
G8 -Fever/malaise; 09 -Other; A1 -SIDS ...

VIRUS OR VIRAL ANTIGEN	Eye	Genital	Endo/sal gland	RES	Muscle/joint	Congenital	PUO	Fever/malaise	Other	SIDS
0101 ADENOVIRUS TYPE 1.....								2	1	
0102 ADENOVIRUS TYPE 2.....						1		2		
0103 ADENOVIRUS TYPE 3.....								2		
0104 ADENOVIRUS TYPE 4.....									1	1
0110 ADENOVIRUS TYPE 10.....	1									
0114 ADENOVIRUS TYPE 14.....									1	
0201 INFLUENZA A VIRUS.....					1		2	4		
0202 INFLUENZA A VIRUS SUBTYPE H3N2			1					5		
0203 INFLUENZA B VIRUS.....							4	6	4	
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....							1	1	1	
0500 RHINOVIRUS (ALL TYPES).....									1	
0600 MYCOPLASMA PNEUMONIAE.....					1				1	
0809 COXSACKIEVIRUS A9.....								1	1	
0903 COXSACKIEVIRUS B3.....							2	1		
1002 ECHOVIRUS TYPE 2.....							1			
1018 ECHOVIRUS TYPE 18.....								1	1	1
1101 POLIOVIRUS TYPE 1.....								1		3
1102 POLIOVIRUS TYPE 2.....								1		
1300 HERPES VIRUS GROUP-NOT TYPED..	1	1							1	
1302 EPSTEIN-BARR VIRUS (EB VIRUS).			4	1				5	4	
1303 VARICELLA-ZOSTER VIRUS.....									2	
1306 HERPES SIMPLEX TYPE 1.....	5	60	1					1	7	
1307 HERPES SIMPLEX TYPE 2.....	1	218				1			3	
1401 COXIELLA BURNETI.....								1		
1522 RUBELLA VIRUS.....				1					1	
1532 HEPATITIS B ANTIGEN.....									6	
1535 HEPATITIS A ANTIBODY.....								2		
1541 CHLAMYDIA A - C.TRACHOMATIS...	1	109								
1556 CMV - CYTOMEGALOVIRUS.....	3	2	2			8		7	17	
9992 ROSS RIVER VIRUS.....					1					
Total.....	12	390	8	2	3	10	10	43	53	5