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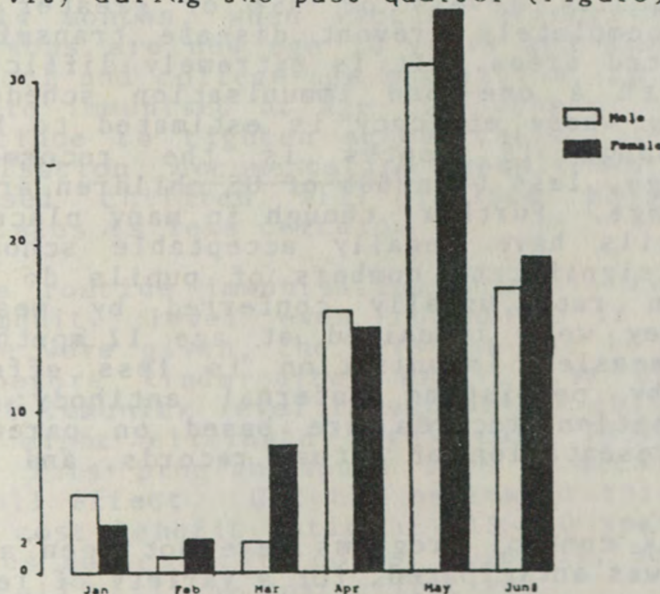
VIRUS REPORTING SCHEME: A total of 1,354 reports were processed for this period.

Twenty-nine cases of Q fever were reported (3 from New South Wales, 3 from Victoria, 2 from South Australia and 21 from Queensland). Occupational exposure data were only available for the two South Australian cases, male meatworkers aged 20 and 49 years respectively, and for 12 Queensland cases, all male meatworkers:

. 4 from Maryborough, aged 17, 20, 34 and 36 years respectively
. 2 from Wondai, aged 21 and 22 years respectively
. 3 from Brisbane, aged 16, 17 and 18 years respectively
. 1 from Beenleigh, aged 29 years
. 1 from Roma, aged 23 years
. 1 from Toowomba aged 39 years

There has been evidence of an increase in Respiratory Syncytial Virus (RSV) activity during the past quarter (Figure).



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Eighty percent of the reported cases involved children under five years of age who presented with moderate to severe upper respiratory tract infections. No deaths have been recorded.

A high level of activity of RSV in children of this age group during the winter months is expected this year on the basis of previous years reports.

Dengue fever, serotype 1, acquired outside Australia was reported in a 60 year old male missionary from Brisbane.

Fifty three isolates of Ross River virus were reported from Laboratories in three states - Queensland (50 isolates), Victoria (1) and Western Australia (2).

THE USA EXPERIENCE - ELIMINATION OF INDIGENOUS MEASLES

(Based on California Morbidity April 4 1986)

In the United States of America, although measles vaccine was licensed in 1963 and despite a nationwide campaign launched in 1978 with a target of eliminating indigenous measles by 1982, the USA still has around 1500-3500 reported cases of measles annually.

The elimination campaign featured increased efforts at universal routine childhood immunisation, including school entry immunisation law enforcement, and aggressive disease surveillance and outbreak control programs.

Why hasn't measles been eliminated?

First, importations of infection from abroad continued, and still continue, at a high rate. Second, as mathematical model studies had predicted, measles is so highly infectious that population immunity levels of 95% or greater appear to be necessary to completely prevent disease transmission in more densely populated areas. It is extremely difficult to achieve this level with a one-dose immunisation schedule using the current vaccine whose efficacy is estimated to be around 95%. Currently, though 15 months is the recommended measles immunisation age, less than 80% of US children are immunised by two years of age. Further, though in many places 98% or more of school pupils have legally acceptable school records of immunisation, significant numbers of pupils do not enjoy the 95% protection rate usually conferred by measles vaccine, because: a) they were immunised at age 12 months or slightly older, when measles immunisation is less effective due to interference by persisting maternal antibody; or b) their school immunisation records are based on parental affidavit rather than presentation of actual records, and they cannot be corroborated.

Third, outbreak control programs have not been as consistently successful as was anticipated, for a variety of reasons:

- identification, immunisation, isolation and follow-up on individual susceptible close personal contacts of measles cases suffers from compliance problems, delayed and incomplete case reporting, and from the fact that measles spreads so rapidly.

- door-to-door immunisation efforts around the residences of cases usually are not very helpful because of the great mobility of cases in a motorised society.
- news media campaigns encouraging immunisation in outbreak areas do not produce enough of a response in the target population.
- school outbreak control programs, where school immunisation records are audited and pupils without legally acceptable records are promptly excluded from further attendance unless they obtain immunisation, have had some impact, but they suffer from the following problems: a) Outbreaks not infrequently move quickly into new communities outside the school exclusion program zone; b) some outbreaks are sustained largely or completely by transmission in preschoolers and young adults, who are obviously outside the purview of school exclusion programs; c) Recently, outbreaks have erupted and persisted in school populations where 98% or more of the pupils have legally adequate measles immunisation records, so that audit/exclusion campaigns employing the usual exclusion criterion of a legally inadequate immunisation record have had little impact.

What can be done to hasten elimination of measles?

Measles importations from abroad can be reduced by strengthening of immunisation programs in other countries and by U.S. citizens born since 1956 (nearly everyone born before then is immune) paying careful attention to their immunisation status before traveling abroad.

Even if the routine immunisation program in the U.S. is not changed, the immunity level among school pupils and young adults will continue to rise somewhat over the next 1-2 decades, for two reasons. First, persons immunised between ages 12 and 14 months, when vaccine effectiveness is lower (most such persons are now age 10 years and older), will move out of the school and college-age population, to be replaced by persons who were immunised at age 15 months or older. Second, as states continue to tighten school/child care centre entry measles immunisation documentation requirements cohorts of better immunised children will replace those whose true immunisation status is less certain.

Changes in the routine immunisation schedule could boost the population immunity level even further. If two doses of measles vaccine were given, the first at age 15 months and the second just before kindergarten entry, the ultimate result should be a 99% immunity level in school-age children and young adults, which might eliminate significant indigenous measles transmission. This program would take a decade or more to achieve its full effect. CDC has estimated this would result in a negative cost benefit ratio of $15-$30 spent for every $ saved on measles medical care costs. Overall, however, measles immunisation would still be cost effective.

A two-dose vaccine schedule could achieve its impact more quickly if, in addition to giving the second dose to successive cohorts of kindergarten entrants, an initial one-time campaign to reimmunise all school children ages 5-18 years were undertaken. CDC staff estimate that this program would cost

$100 million at the outset, a prohibitive figure. A variant on the program would be to limit the one-time reimmunisation of current school children to those previously immunised between ages 12 and 14 months. Such a program would require, in addition to immunisation expenses, the expense of a nationwide audit of school immunisation records to identify pupils to be reimmunised, and its total initial cost is estimated to be $30-$35 million. Also, there is no guarantee that reimmunisation of just this subgroup of school-age children would promptly eliminate measles transmission.

Outbreak control strategies can be strengthened, for example, when school measles outbreaks occur to immediately reimmunise pupils who were initially immunised between the ages of 12 to 14 months.

In conclusion, the already low measles incidence in the U.S. will probably slowly decline somewhat further. However, if trends of recent years are an indication, without a rather costly change in immunisation strategy it may be that measles transmission, with at least small to moderate-sized outbreaks, will continue in the U.S. for quite a few years.

CDI Comment

As advised previously (CDI 86/9) a national bicentennial campaign is to be launched to control measles in Australia.

The lesson from the USA is that, even with enforcement of immunisation at school entry and a subsequent high population immunity level, elimination has not been achieved.

In Australia with voluntary immunisation and lower population immunity the problem of eradication/control is greater.

MEASLES CASES IN CANADA

(Based on MMWR (1986) 20, 331-333)

Between January 1, and April 12, 1986, 7,941 measles cases in Canada were reported to the Laboratory Centre for Disease Control, a greater than 20-fold increase over the corresponding period in 1985, and the largest number of measles cases reported since 1979.

The overall incidence rate for Canada was 31 cases per 100,000 population.

Age data are available for 5,260 (98%) of the 5,367 cases reported in Canada during 1985 and the first 2 1/2 months of 1986 (Table 1). In the current outbreak thirty-six percent of cases occurred among 10 to 14 year-olds; 29%, among 15 to 19 year-olds; and 21%, among 5 to 9 year-olds. The highest incidence rate (104/100,000) occurred for 10 to 14 year-olds. The rate for 15 to 19 year-olds and 5 to 9 year-olds was 77 cases and 61 cases/100,000, respectively. In 1985, 10 to 14 year-olds also had the highest incidence rate (45/100,000).

TABLE 1. Age distribution of measles patients of known age - Canada, January-December 1985 and January 1-March 15, 1986

Age (yrs.)	1985			1986		
	No.	(%)	Rate*	No.	(%)	Rate+
1	142	(5.3)	37.5	105	(2.0)	27.7
1-4	315	(11.9)	21.3	368	(7.3)	26.1
5-9	666	(25.0)	37.4	1,096	(20.8)	61.5
10-14	821	(30.9)	45.3	1,893	(36.0)	104.4
15-19	593	(22.3)	30.1	1,522	(28.9)	77.1
20-24	48	(1.8)	2.0	144	(2.7)	6.0
25-29	27	(1.0)	1.2	44	(0.8)	1.9
30	49	(1.8)	0.4	70	(1.3)	0.5
TOTAL	2,661			5,260		

* Per 100,000 population.
\+ Rate for the first 2 1/2 months only; annual rate likely to be substantially higher.

Investigations of some of the current outbreaks indicate that over half of patients had histories of measles vaccination. Although most patients have histories of receiving live measles vaccine, the proportion who received adequate immunisation (according to current definitions) is not known. Further epidemiologic investigations are ongoing. Of interest is that, in British Columbia, between 1969 and 1974, half-doses of live measles vaccine were administered to conserve vaccine supply. In addition, many children in Canada may have received further attenuated live measles vaccine and human immune globulin simultaneously, or live attenuated measles vaccine within 6 weeks after immune globulin, killed measles vaccine, or vaccine at under 12 months of age.

MMWR Editorial Note

Measles vaccine of several types, including inactivated vaccine, has been used in Canada since 1964[1]. All provinces now routinely use further attenuated measles vaccine combined with mumps and rubella (MMR), which is recommended for use at or after 12 months of age[2]. The mean annual measles incidence rate decreased from 358 cases/100,000 during the prevaccine era (1949-1958) to 30/100,000 during 1976-1985, a 92% reduction. The highest rate during the past 10 years was in 1979 95/100,000. The lowest reported incidence occurred in 1983 4/100,000.

Measles elimination has been a priority since the early 1980s in all provinces[3]. Ontario, New Brunswick, and Manitoba, representing 43% of Canada's population, introduced legislation in 1981, 1982, and 1985, respectively, making measles vaccination compulsory for school entry. Provinces without school immunisation laws have used intensive education efforts to encourage vaccination and report that over 95% of children are vaccinated by the time they reach school age. The current measles outbreaks in Canada are probably attributable to accumulation of susceptibles due to unvaccinated school-aged children who started school before widespread use of measles vaccine in Canada, persons inappropriately vaccinated and vaccine failures.

In the United States, measles vaccine is recommended for all children 15 months of age or older. However, the age at vaccination is lowered for those children travelling to areas where measles is endemic or epidemic. Children 12-14 months of age may receive MMR before their departure, with no need for revaccination. Children 6-11 months of age may receive single measles antigen vaccine (without rubella or mumps antigens) before departure but must be revaccinated with MMR vaccine. The optimal age for revaccination is 15 months, although the age for revaccination may be as young as 12 months if the children remain in high-risk areas.

References

1. Rev Infect Dis 1983; 5: 445-51.
2. National Advisory Committee on Immunisation, Health and Welfare, Canada. A guide to immunization for Canadians. Ottawa, Ontario, Canada: Minister of Supply and Services, 1980.
3. Rev Infect Dis 1983; 5: 577-82.

TUBERCULOSIS IN A DOCTOR AT A CHILDRENS HOSPITAL: CONTACT TRACING

(Based on CDR (1986) 20:3)

A senior resident medical officer was diagnosed as having pulmonary tuberculosis in September 1983, 2 weeks after commencing a six month post at a children's hospital in Liverpool (UK). Although he had only a slight cough his chest X-ray showed multiple cavities in the right upper lobe and his sputum was strongly smear positive, indicating open tuberculosis.

Inpatients, outpatients, hospital personnel and children (including siblings, parents and other children who accompanied the child to hospital) attending the Accident and Emergency Department where the doctor worked, were contact traced and screened for tuberculosis.

The screening of parents and hospital staff did not identify any case of TB. However, the screening of 174 out of the 177 children (168 patients and 9 siblings defined as possible contacts) identified a 5 year old boy with a grade 3 Tine test and a strongly-positive Mantoux reaction (20 mm). Although his chest X-ray was normal, it is not known whether this strongly positive Mantoux was due to contact with the doctor or a previous infection. He was given isoniazid for 1 year. The child had an uncle who had had a positive Heaf test at a routine screen at school in the past. There was no evidence of tuberculosis in the family.

In this instance, such screening generated a considerable amount of work for a number of sectors of the Health Service. The contact tracing involved the enlargement of an existing tuberculosis clinic, extra work for the already busy TB health visitors and occupational health staff and an enormous amount of work for medical and secretarial staff involved in tracing and reviewing patients cards and case notes.

TETRACYCLINE-RESISTANT NEISSERIA GONORRHOEAE (USA)
(based on MMWR Vol.35/No 19, 16 May 1986)

In February 1985, the Centers for Disease Control (CDC), Atlanta, identified the first isolates of Neisseria gonorrhoeae that have high-level resistance to tetracycline (minimal inhibition concentration [MIC] 24-32 ug/ml) but are susceptible to penicillin. This high level of tetracycline resistance appears to be a new phenomenon(1).

The identification of N.gonorrhoeae and the level of antibiotic resistance were confirmed by standard biochemical and immunologic methods. None of these strains produced B-lactamase. Isolates were tested at CDC by agar dilution method for sensitivity to penicillin, ampicillin, tetracycline, minocycline, doxycycline, cefotaxime, cefuroxime, cefoxitin, spectinomycin, and trimethoprim/sulfamethoxazole. All were resistant to tetracycline (MIC 16-32 ug/ml), doxycycline (MIC 8-24 ug/ml) and minocycline (MIC 12-32 ug/ml). The isolates were unformly susceptible to penicillin (MIC 0.008-0.25 ug/ml) and the other antibiotics tested. All the isolates were proline auxotrophs and belonged to serogroup IB with three distinct serovariants represented. Of the 13 isolates tested all contained plasmids of approximately 24.5 and 2.6 megadaltons. Genetic analysis indicated that deoxyribonucleic acid (DNA) from these strains did not hybridise to a known enteric tetracycline resistance determinant, nor were these strains able to function as genetic donors of tetracycline resistance to sensitive strains of N.gonorrhoeae either by conjugation or by DNA-mediated transformation.

Between February 1985 and March 1986, 3 of 79 cases of plasmid-mediated tetracycline resistant N.gonorrhoeae infection (TRNG), all from Massachusetts, have been confirmed as combined tetracycline-resistant penicillinase-producing N.gonorrhoeae (TRNG-PPNG). Sixty five (82%) of the confirmed TRNG cases were isolated from three States - Georgia (31 cases), Massachusetts (23), and Oregon (11). The Oregon cases were all from an outbreak among homosexual men in the Portland area, and their details were as follow:

- Case 1 was a 32 year old homosexual male presenting with a 3-day history of urethral discharge and dysuria. Following a positive diagnosis of gonorrhoea, the patient was prescribed oral tetracycline because of his allergy to penicillin. The patient was still symptomatic one week later and had a positive urethral culture for gonorrhoea. The isolate was confirmed as high-level TRNG with an MIC=32 ug/ml.
- Cases 2 to 11 were homosexual males infected at rectal (three patients), urethral (two), rectal and urethral (four), and pharyngeal (one) sites. All cases were of the same auxotype and serovar class, suggesting the isolates were of clonal origin. Subsequent contact-tracing further identified:
  - Six additional cases of gonococcal-disease including two out-of-state cases
  - Nineteen contacts (including 15 bathhouse contacts of one patient) which could not be traced due to lack of adequate identifying and locating information.

In response to this outbreak, the local health authority instituted ceftriaxone as the drug of choice for all gonococcal infections among homosexual males. Educational efforts targetted at both the professional and lay community were intensified toward increased TRNG awareness.

MMWR EDITORIAL NOTE:

The rapid onset of the outbreak and the identification of combined PPNG-TRNG strains in the above states demonstrate the potential for rapid dissemination of new gonococcal strains into a community, and the ability of N.gonorrhoeae to acquire multiple drug-resistant determinants. The latter includes such combinations as plasmid-mediated resistance (eg PPNG-TRNG), plasmid and chromosomally-mediated resistance (eg spectinomycin-resistant PPNG) or chromosomally-mediated resistance to multiple antibiotics.

The largest numbers of TRNG cases were described from areas where active surveillance programs were in operation. With the exception of testing for B-lactamase, most areas in the United States do not routinely perform antimicrobial susceptibility testing on gonococcal isolates. Therefore, the incidence of resistant strains that do not present as treatment failures is not known.

Tetracycline (doxycycline, minocycline) therapy alone is not recommended for the treatment of gonococcal infections. In view of the increasing geographic distribution and the complexity of antimicrobial resistance in N.gonorrhoeae and the increasing need for effective surveillance of new cases, CDC is currently preparing comprehensive guidelines for susceptibility testing.

REFERENCES

1. MMWR (1985) 34:563-70

GONOCOCCAL SURVEILLANCE AUSTRALIA
OCTOBER-DECEMBER 1985

(Contributed by the Australian Gonococcal Surveillance Programme (AGSP) Co-ordinator Dr JW Tapsall, The Prince of Wales Hospital, Randwick, New South Wales 2031)

The present report provides details of pencillin sensitivities for the period October-December 1985 of 983 isolates of Neisseria gonorrhoea, examined by participating State and Territory Laboratories using Standard techniques and procedures[1].

In this quarter penicillinase-producing gonococci (PPNG) were isolated in all centres with the exception of Hobart and Canberra (Table). High rates of PPNG infection were observed in Sydney, Melbourne and Brisbane and the available evidence that a high proportion of the PPNG infections were acquired locally rather than overseas:

. Sydney 20 of 30 PPNG infections (67%) were acquired locally
. Melbourne 15 of 39 PPNG infections (38.5%) were acquired locally
. Brisbane 7 of 18 PPNG infections (39%) were acquired locally

In Perth and Adelaide where lower rates of PPNG infections were recorded, all PPNG were acquired overseas. However in Darwin PPNG were isolated from locally acquired infections.

The proportion of locally acquired PPNG infections has now reached a level which necessitates the use of antibiotics other than penicillin and its derivatives. A number of clinics are presently using alternative antibiotics routinely in response to the high rate of PPNG in the communities they serve.

The report also features the appearance of a cluster of cases of penicillin resistant non-PPNG which occurred in Perth during this period, the first such incident noted in Australia. Although uncommon here, such strains have caused outbreaks of infections overseas[2].

Table : Penicillin sensitivity of isolates of N.gonorrhoeae[3]
October-December 1985

Centre	Percentage of isolates		
	Sensitive	less sensitive	PPNG
Brisbane	28.19 (29.9)*	55.85 (60.0)	9.58 (2.8)
Sydney	6.36 (12.8)	76.8 (70.0)	13.64 (5.9)
Melbourne	11.23 (15.4)	63.61 (56.0)	13.27 (10.8)
Adelaide	38.73 (44.0)	34.13 (45.0)	1.59 (1.0)
Perth	43.04 (35.7)	27.85 (38.5)	5.06 (5.0)

* Figures in parenthesis represent data for the corresponding period in 1984.

REFERENCES

1. Br J Vener Dis (1984) 60:226-230.
2. NEJM (1985) 313:607-611
3. Communicable Disease Intelligence (CDI) Bulletin 85/23

SCRAPIE IN SWEDEN
(Based on Exotic Animal Diseases Bulletin No 12 - June 1986)

The Swedish Chief Veterinary Officer has advised the Office International des Epizooties (OIE) that two sheep in a small flock in middle Sweden were found to show progressive clinical signs typical for scrapie. Histopathological examination of the sheep brains has confirmed the disease. All sheep in the flock have been destroyed and studies with experimental animals have commenced. Scrapie has previously never been diagnosed in Sweden, and the origin of the recent outbreak is unknown.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD 9/6/86 - 22/6/86 BULLETIN NUMBER 86/13

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	4	1	2	1	1		18	1	28
0101 ADENOVIRUS TYPE 1								4	4
0102 ADENOVIRUS TYPE 2				2	3			3	8
0106 ADENOVIRUS TYPE 6							1	1	2
0107 ADENOVIRUS TYPE 7				1					1
0108 ADENOVIRUS TYPE 8	2			2					4
0111 ADENOVIRUS TYPE 11	2								2
0199 ADENOVIRUS TYPING PENDING			2		2				4
0201 INFLUENZA A VIRUS						2			2
0203 INFLUENZA B VIRUS	1								1
0301 PARAINFLUENZA VIRUS TYPE 1	2	2		1	3	1	2		11
0302 PARAINFLUENZA VIRUS TYPE 2				1	20	4			25
0303 PARAINFLUENZA VIRUS TYPE 3					3		2		5
0399 PARAINFLUENZA VIRUS TYPING PENDING		1							1
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	12	6	7	2	4	1	13		45
0500 RHINOVIRUS (ALL TYPES)	1			4	4	3		1	13
0600 MYCOPLASMA PNEUMONIAE	5	2	2				7	2	18
0700 ORNITHOSIS-PSITTACOSIS	2					3			5
0816 COXSACKIEVIRUS A16	1								1
0905 COXSACKIEVIRUS B5						1			1
1005 ECHOVIRUS TYPE 5	2								2
1011 ECHOVIRUS TYPE 11	1							2	3
1014 ECHOVIRUS TYPE 14	1								1
1020 ECHOVIRUS TYPE 20								1	1
1021 ECHOVIRUS TYPE 21					2				2
1022 ECHOVIRUS TYPE 22						2			2
1100 POLIOVIRUS NOT TYPED			7						7
1101 POLIOVIRUS TYPE 1								2	2
1102 POLIOVIRUS TYPE 2		1							1
1103 POLIOVIRUS TYPE 3						1		1	2
1200 MUMPS VIRUS	1							3	4
1300 HERPES VIRUS GROUP-NOT TYPED	16					1		3	20
1301 HERPES SIMPLEX VIRUS NOT-TYPED		1		1					2
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	9	1		3				7	20
1303 VARICELLA-ZOSTER VIRUS	2		1			2	1	2	8
1306 HERPES SIMPLEX TYPE 1	12		12	35		19	30	31	139
1307 HERPES SIMPLEX TYPE 2	62		5	63		22	66	76	294
1399 HERPES VIRUS TYPING PENDING					6				6
1401 COXIELLA BURNETI	3			3		2	21		29
1502 PICORNA VIRUS-NOT TYPED	2		7				8	2	19
1521 MEASLES VIRUS		1	2						3
1522 RUBELLA VIRUS	2						14	2	18
1532 HEPATITIS B ANTIGEN	61	1	3	23		16	17	22	143
1535 HEPATITIS A ANTIBODY	3			6		17	1	25	52
1541 CHLAMYDIA A - C TRACHOMATIS	21		7			31	7	91	157
1556 CMV - CYTOMEGALOVIRUS	4	3	1	18	5		22	12	65
1563 CORONAVIRUS	1								1
1564 ROTAVIRUS	6	5	3		10	43		3	70
1569 ENTEROVIRUS TYPE 69		1							1
1571 ENTEROVIRUS TYPE 71 (BRCR)					16				16
1599 ENTEROVIRUS TYPING PENDING			7		13				20
9990 AUSTRALIAN ENCEPHALITIS							1		1
9992 ROSS RIVER VIRUS				1			50	2	53
9993 ASTROVIRUS	2								2
9994 SMALL VIRUS (LIKE) PARTICLE		4		1					5
9995 DENGUE							1		1
9998 ARBO. GROUP B. ...							1		1
Total	243	30	68	168	92	171	283	299	1,354

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 9/6/86 - 22/6/86
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	Respiratory	Encephalitis	Meningitis	Paralysis	CNS other unspec	GI	Hepatic	CVS	Urinary	Skin/mucs memb
0100 ADENOVIRUS NOT TYPED		1									
0101 ADENOVIRUS TYPE 1	1	1				1	2				
0102 ADENOVIRUS TYPE 2		1		1		2	2				
0106 ADENOVIRUS TYPE 6							1				
0107 ADENOVIRUS TYPE 7		1									
0111 ADENOVIRUS TYPE 11							1				
0201 INFLUENZA A VIRUS		2									
0203 INFLUENZA B VIRUS		1									
0301 PARAINFLUENZA VIRUS TYPE 1		11									
0302 PARAINFLUENZA VIRUS TYPE 2		24									
0303 PARAINFLUENZA VIRUS TYPE 3		5									
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	2	41			1						
0500 RHINOVIRUS (ALL TYPES)		10			1						
0600 MYCOPLASMA PNEUMONIAE	2	15						1			
0700 ORNITHOSIS-PSITTACOSIS	1	4									
0816 COXSACKIEVIRUS A16											1
0905 COXSACKIEVIRUS B5		1									
1005 ECHOVIRUS TYPE 5		1		1							
1011 ECHOVIRUS TYPE 11		2		1							
1020 ECHOVIRUS TYPE 20							1				
1021 ECHOVIRUS TYPE 21		1		1							
1022 ECHOVIRUS TYPE 22	1										
1103 POLIOVIRUS TYPE 3	1										
1200 MUMPS VIRUS		4						1			
1300 HERPES VIRUS GROUP-NOT TYPED	2										1
1301 HERPES SIMPLEX VIRUS NOT-TYPED			1								
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	4	1						2		1	1
1303 VARICELLA-ZOSTER VIRUS	2	1		1		1					5
1306 HERPES SIMPLEX TYPE 1	5	11						1		1	72
1307 HERPES SIMPLEX TYPE 2	4									1	85
1401 COXIELLA BURNETI	3	5							1		
1502 PICORNA VIRUS-NOT TYPED	2	2		1		3	8				
1521 MEASLES VIRUS						1					1
1522 RUBELLA VIRUS	2										15
1532 HEPATITIS B ANTIGEN	52	1					1	73			
1535 HEPATITIS A ANTIBODY	11							37			
1541 CHLAMYDIA A - C.TRACHOMATIS	11										
1556 CMV - CYTOMEGALOVIRUS	7	14			1	1		5		6	
1563 CORONAVIRUS							1				
1564 ROTAVIRUS						1	67				
1569 ENTEROVIRUS TYPE 69							1				
1571 ENTEROVIRUS TYPE 71 (BRCR)		2		4		1					8
1599 ENTEROVIRUS TYPING PENDING		2									
9990 AUSTRALIAN ENCEPHALITIS		1									
9992 ROSS RIVER VIRUS	7	3						2			8
9993 ASTROVIRUS							2				
9994 SMALL VIRUS (LIKE) PARTICLE				1			5				
9995 DENGUE	1										
Total	121	169	1	11	3	11	92	122	1	9	197

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 9/6/86 - 22/6/86
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
0102 ADENOVIRUS TYPE 2.............							1	1		1
0107 ADENOVIRUS TYPE 7.............								1		
0108 ADENOVIRUS TYPE 8.............	4									
0111 ADENOVIRUS TYPE 11............									1	
0203 INFLUENZA B VIRUS.............								1		
0302 PARAINFLUENZA VIRUS TYPE 2....										1
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)............................							1			
0500 RHINOVIRUS (ALL TYPES)........								2	1	
0600 MYCOPLASMA PNEUMONIAE.........							1	2		
0700 ORNITHOSIS-PSITTACOSIS........								1		
1014 ECHOVIRUS TYPE 14.............							1			
1022 ECHOVIRUS TYPE 22.............										1
1101 POLIOVIRUS TYPE 1.............										2
1102 POLIOVIRUS TYPE 2.............									1	
1103 POLIOVIRUS TYPE 3.............										1
1301 HERPES SIMPLEX VIRUS NOT-TYPED									1	
1302 EPSTEIN-BARR VIRUS (EB VIRUS).			6	5				3		
1306 HERPES SIMPLEX TYPE 1.........	6	42						1	4	
1307 HERPES SIMPLEX TYPE 2.........		205							1	
1401 COXIELLA BURNETI..............					6		2	22	1	
1502 PICORNA VIRUS-NOT TYPED.......										2
1521 MEASLES VIRUS.................								1		
1522 RUBELLA VIRUS.................			1		4			5	1	
1532 HEPATITIS B ANTIGEN...........									16	
1535 HEPATITIS A ANTIBODY..........									4	
1541 CHLAMYDIA A - C.TRACHOMATIS...	2	140				1			3	
1556 CMV - CYTOMEGALOVIRUS.........		2	1	1	2	2	1	7	18	
1564 ROTAVIRUS.....................		2								
1571 ENTEROVIRUS TYPE 71 (BRCR)....					1		1			
9990 AUSTRALIAN ENCEPHALITIS.......					1					
9992 ROSS RIVER VIRUS..............					37			16		
9998 ARBO. GROUP B.					1			1		
Total..............................	12	391	8	6	52	3	8	64	52	8

NOTIFIABLE DISEASES REPORTED IN AUSTRALIA

Period 1 - 1 January 1986 - 24 January 1986

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Disease	N.S.W.	VIC	QLD	S.A.	W.A.	TAS.	N.T.	A.C.T.	Total	CUMULATIVE TOTAL TO DATE FOR YEAR
Amoebiasis		1	1						2	2
Ankylostomiasis							N.N.		–	–
Anthrax									–	–
Arbovirus infection	38		39		2				79	79
Brucellosis			3						3	3
Campylobacter infections	137	N.N.	N.N.	101	3	N.N.	1	N.N.	242	242
Chancroid				N.N.		N.N.			–	–
Cholera									–	–
Congenital rubella syndrome		N.N.	N.N.			N.N.		N.N.	–	–
Diphtheria							3		3	3
Donovanosis		N.N.		N.N.	3	N.N.	2		5	5
Giardiasis	20	N.N.	N.N.	49	2	N.N.	N.N.	N.N.	71	71
Genital herpes	62	N.N.	5	17	N.N.	N.N.			84	84
Gonococcal ophthalmia neonatorum		N.N.	N.N.		N.N.	N.N.		N.N.	–	–
Gonorrhoea	92		41	58	122	1	44	1	359	359
Hepatitis A (infectious)	22	8	21	27	43		3	.	124	124
Hepatitis B (serum)	46	22	36	9	8	1	1	1	124	124
Hepatitis - unspecified	7		3	1		N.N		1	12	12
Hydatid disease		1							1	1
Lassa Fever		N.N	N.N.			N.N.	N.N.	N.N.	–	–
Legionnaires' disease	2		N.N.	8		N.N.		N.N.	10	10
Leprosy	3								3	3
Leptospirosis	3	3	8				1		15	15
Lymphogranuloma venereum		N.N.	N.N.	N.N.	N.N.	N.N.			–	–
Malaria	16	11	18	3	4		4	5	61	61
Marburg Disease		N.N.	N.N.			N.N.	N.N.	N.N.	–	–
Meningococcal infections	1					N.N.	1		2	2
Non-specific urethritis	215	N.N.	1	109		N.N.		N.N.	325	325
Ornithosis		2		1					3	3
Pertussis (whooping cough)	58	13	N.N.	38	10	N.N.		N.N.	119	119
Plague									–	–
Poliomyelitis									–	–
Q. fever	1		13	1			N.N.		15	15
Rabies		N.N	N.N.	N.N.		N.N.	N.N.	N.N.	–	–

2.

DISEASE	N.S.W.	VIC	QLD	S.A.	W.A.	TAS.	N.T.	A.C.T.	Total	CUMULATIVE TOTAL TO DATE FOR YEAR
Salmonella infections	99	27	29	17	23	6	29	3	233	233
Shigella infections	23	8	10	7	12		11		71	71
Smallpox										
Syphilis	29		7	12	11		48	1	108	108
Tetanus										
Trachoma		N.N.			4	N.N.	N.N.	4		4
Tuberculosis (all forms)	9	27	3	5	11		1	N.N.	56	56
Typhoid fever	1		1						2	2
Typhus (all forms)										
Vibrio parahaemolyticus infections	1	N.N.	N.N.	1		N.N.		N.N.	2	2
Yellow Fever										
Yersinia enterocolitica infections	4	N.N.	N.N.			N.N.		N.N.	4	4

(Note: Data collected under the Notifiable Diseases Returns may bear little or no correlation to that collected under the CDI laboratory scheme. Whilst the latter is a sampling program, the Notifiable Diseases data is dependant upon voluntary reporting by medical practitioners etc.)

N.N. Not Notifiable

IMPORTANT NOTICE

Our ref 86/4465

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