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Communicable Diseases Intelligence

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Contents:

Editor: Dr I F Cook

VIRUS REPORTING SCHEME A total of 1 537 reports were processed for this period.

Fourteen cases of Q fever were reported (1 from New South Wales, 3 from Victoria and 10 from Queensland). Occupational exposure data were only available for two Brisbane meatworkers, a 35 year old female and an 18 year old male. None of these fourteen patients were involved in the Q fever vaccine field trial conducted in South Australia.

Cytomegalovirus (CMV) was isolated from the breast milk of a 23 year old female whose child had congenital CMV. It is not known whether the child had acquired the infection post partum via breast milk.

Regular monitoring of Respiratory Syncytial Virus activity indicated a further increase with 241 cases reported for this period. Unusual presentation included meningitis, paralysis and fever of unknown origin.

CHOLERA: HONG KONG

Hong Kong health authorities have advised that there are currently 22 confirmed cholera cases and 33 suspected patients are still under observation in the isolation ward of the Princess Margaret Hospital.

The last confirmed local case was reported on Saturday 9 August 1986. If no further cases are notified within the next few days then the authorities will give the all clear. However WHO reported that Hong Kong has been declared an infected area following such cholera outbreak.

Local control measures have been instituted and the incident has no implications for international travellers. Health authorities confirm that a cholera vaccination certificate is not required for visitors entering Kong Kong. Cholera vaccinations can however be obtained at the airport for those

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passengers travelling from Kong Kong to countries which require cholera certificate.

The CDI will keep readers posted of further developments.

GIARDIASIS IN THE SOVIET UNION

(Based on California Morbidity No 25. 27 June 1986)

Giardia lamblia is a protozoan parasite of the small intestine. Infection with this organism can be symptom-free or can be associated with symptoms resembling a malabsorption syndrome. The symptoms include diarrhoea, which is often greasy and malodorous, abdominal cramps, fatigue, weight loss, flatulence, anorexia and nausea. Fever and vomiting are uncommon. The incubation period is 1 to 14 weeks, and the duration of illness when untreated varies from 2 weeks to several months.

Giardiasis in travellers returning from the Soviet Union has been recognised in the United States since 1969. Patients usually become symptomatic toward the end of their trip or shortly after their return home. Data on 47 tour groups travelling to Russia between 1972 and 1973 showed that 23 percent of 1,419 persons were ill with giardiasis. In prospective studies, 80 percent of American and 35 percent of Finnish travellers to Leningrad who were stool negative for Giardia on departure to the Soviet Union developed symptoms of giardiasis and were stool positive for Giardia when they returned home. These data, as well as more recent data, continue to implicate Leningrad as the principal site of infection within the Soviet Union, with ingestion of tap water as the probable mode of transmission. While travellers to Mexico and several countries in Asia, Africa, South America and Central America may also risk infection, fewer than 3 percent of travellers with diarrhoea returning from these countries have been found to be infected with Giardia.

There is no known chemoprophylaxis for giardiasis. Travellers to an endemic area should be advised that the best way to prevent infection is to eat only foods that can be peeled or have been cooked, and to drink only boiled water or bottled carbonated water, other beverages that have been boiled, bottled carbonated soft drinks, beer, or wine. Tap water used for brushing teeth and for ice in drinks may also be a source of infection. In the environment, Giardia lamblia exists as a hardy cyst which can survive for at least 2 months in cold (4^0C) water and for at least several days in tap water (15^0-20^0C). The cyst is also resistant to amounts of chlorine (0.5mg/L) routinely used to disinfect municipal water supplies in the U.S.

CDI editorial comment

This report emphasises two important points in the management of communicable diseases. The first is that some infections have long incubation periods - up to 14 weeks in the case of Giardiasis. Medical practitioners should, therefore, consider the possibility that a patient has been exposed to a pathogen for up to about 3 months prior to disease onset. The second is that an adequate travel history should always be taken whenever

a communicable disease is suspected. This is particularly important where the signs and symptoms are consistent with a disease which is rare or non-existent in the locality where the symptoms first present.

The risk of an incorrect diagnosis, with concomitant patient distress in the latter case is markedly increased where a travel history is not taken. As stated earlier, giardiasis symptoms can resemble those of a malabsorption syndrome, and there is no place for unnecessary and expensive diagnostic procedures where a simple stool cultured and antibiotic treatment will suffice.

MILKBORNE SALMONELLOSIS - CAMBRIDGE (U.K.)

(Based on PHLS Microbiol Digest (1986) 3:56)

Contaminated pasteurised milk was identified as the vehicle of infection in a recent episode of milkborne salmonellosis involving 26 primary cases and several asymptomatic excreters of Salmonella Braenderup.

Five asymptomatic excreters of the same serotype were identified on a farm which supplied raw milk to the dairy associated with the outbreak. The organism was also found in bulk milk and milking equipment on the farm. Pasteurised milk may have been contaminated in the dairy when mixed with raw milk. Operational procedures in the dairy are being investigated to determine how the accident happened.

Salmonellosis infection has usually been associated with drinking raw cow's milk and infection due to pasteurised milk is uncommon. Of the 201 milkborne salmonellosis outbreaks reported to the Public Health Laboratory Services for the past 45 years, 2 were traced to pasteurised milk, 7 implicated dried milk and 192 were due to raw milk.

In the 2 salmonellosis outbreaks implicating pasteurised milk salmonella typhimurium was isolated in:-

- 1955 from 17 cases who had consumed pasteurised milk infected by cardboard bottle tops contaminated with mouse faeces;
- 1983/84 from 5 cases who had consumed pasteurised milk infected by defective and contaminated equipment used in a farm pasteurising plant.

CDI Editorial Comment:

The introduction of compulsory pasteurisation has reduced the incidence of milkborne salmonellosis, but the recent U.K. experiences of salmonellosis outbreaks involving pasteurised and dried milk seem to suggest that, in addition to the legislative requirement for milk pasteurisation, a system of term licensing of milk pasteurising plants should be introducted in the U.K. to promote regular inspection and maintenance of appropriate hygience standards in milk processing/pasteurising and drying plants to minimise this mode of infection.

In Australia compulsory, pasteurisation is policed by State Authorities which regularly monitor the Dairy Industries to ensure milk safety, quality and standard for mass consumption.

CAMPYLOBACTER OUTBREAK ASSOCIATED WITH RAW MILK PROVIDED ON A DAIRY TOUR - CALIFORNIA
(based on MMWR Vol. 35/No 19, 16 May 1986)

In October 1985, students and teachers of a northern Californian school and some of their family members made a field trip to a San Joaquin County dairy. Of the 50 people for whom information was available, 39 drank raw milk, and of these 23 (59%) became ill with Campylobacter jejuni infection. None of the 11 who did not drink raw milk became ill ($p = 0.0005$).

One of the cases was an infant who had been almost exclusively breast fed and became ill after drinking a bottle which had been filled with raw milk at the dairy. In addition, secondary cases occurred in two women who had not visited the dairy but who tended an infant who drank raw milk and developed campylobacter gastroenteritis. C. jejuni was cultured from the stools of one asymptomatic and eight ill persons. Neither the milk nor specimens from the cows were cultured.

Of the 23 ill persons, 22 (96%) reported diarrhoea, 8 (35%) abdominal cramps, 8 (35%) fever, 6 (26%) vomiting and 5 (22%) bloody diarrhoea. Incubation periods ranged from 1 day to 10 days but were 3 or 4 days in most cases. Symptoms most commonly lasted 5 days.

MMWR Editorial Note:

As a result of numerous outbreaks of enteric disease occurring among school children drinking raw milk while on field trips to dairies in the United States, the U.S. Food and Drug Administration (FDA) issued in January 1985, a 'milk advisory' to all state school officers recommending that children not be permitted to sample raw milk on such visits.

Healthy lactating cows are known to carry C. jejuni in the intestinal tract, thus providing an extrinsic source of contamination. Recent studies of healthy dairy cows indicated that around 40% had positive rectal cultures[1] and 14% had C. jejuni cultured from the bile[2]. In addition, cows with no evidence of illness can excrete Campylobacter directly into their milk as a result of mammary infection. Between 1980 and 1982, 23 Campylobacter outbreaks were reported to the Centers for Disease Control (CDC). Fourteen of those were traced to consumption of 'raw milk'. Since the culture of diarrhoeal stools for C. jejuni have become common, many Campylobacter outbreaks associated with raw milk and involving thousands of cases have been reported.

Milk is an excellent vehicle for infection, because its fat content protects pathogens from gastric acid and because, being a liquid, it has a relatively short gastric transit time. Present technology cannot produce raw milk that can be assured to be free of pathogens; only with pasteurisation can milk be made safe for human consumption[3]. Since 1983, milk-borne infection in Scotland has decreased markedly following the ban on sale of raw milk[4].

CDI Comment

In Australia, legislation has been introduced in the early 50's at various times in different States, requiring cow's milk to be pasteurised prior to commercial sale for mass consumption. However the sale of raw cow's milk has not been made illegal provided the milk vendor obtained an exemption permit from the relevant State Health Department.

Current legislation does not require goat's milk to be pasteurised. Raw goat's milk sale is however subjected to an existing labelling code which requires that containers of raw goat's milk distributed for sale be labelled as 'unpasteurised raw goat's milk'.

REFERENCES

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2. Am J Vet Res (1986) 47:254-8
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HIV ANTIBODY TESTING IN CHINA
(based on WER (1986) 61:226)

Eighteen haemophiliacs treated with imported factor VIII during the period 1982-1984 were screened for human immunodeficiency virus (HIV) antibody by ELISA. Four haemophiliacs, none of whom had clinical evidence of AIDS, were antibody-positive by ELISA and were confirmed by immunofluorescence and immunoblotting techniques. Two haemophiliacs treated with locally produced factor VIII were seronegative. In addition, 310 sera from 8 provinces and 1 city (220 healthy individuals, 7 healthy persons known to have antibody to HTLV-I and 83 patients with leukaemia) were negative for HIV antibody by immunofluorescence.

One case of serologically confirmed AIDS, in a traveller from abroad who died in Beijing in 1985, has also been reported.

AIDS IN EUROPE TO MARCH 1986
(based on WER (1986) 61:213-214)

As at 31 March 1986, 2 542 cases of AIDS had been reported by the 26 countries participating in the surveillance of AIDS in Europe. Three of the countries, the German Democratic Republic (GDR), Israel and Romania have only recently joined the program and have reported data for the first time. The data is summarised in Table 1.

Table 1. Total number of AIDS cases reported up to 31 March 1986 in 26 European Countries.

Country	March 1985	June 1985	September 1985	December 1985	March 1986
Austria	13	18	23	28	34
Belgium	81	99	118	139	160
Czechoslovakia	-	-	-	-	4
Denmark	41	48	57	68	80
Finland	5	6	10	10	11
France	307	392	466	573	707
German Democratic Republic	...	...	...	...	-
Germany, Federal Republic of	162	220	295	377	459
Greece	7	9	10	13	14
Hungary	...	...	-	-	-
Iceland	-	-	-	...	2
Ireland	...	...	...	8	9
Israel	...	...	...	...	23
Italy	22	52	92	140	219
Luxembourg	...	1	3	3	3
Netherlands	52	66	83	98	120
Norway	8	11	14	17	21
Poland	-	-	-	-	-
Portugal	...	...	...	18	24
Romania	...	...	...	...	1
Spain	29	38	63	83	145
Sweden	22	27	36	42	50
Switzerland	51	63	77	100	113
United Kingdom	140	176	225	287	340
USSR	...	...	-	...	...
Yugoslavia	...	...	1	2	3
TOTAL	940	1 226	1 573	2 006	2 542

... Data not reported.

For the 17 countries participating in AIDS surveillance in Europe at the end of March 1985 (GDR, Hungary, Ireland, Israel, Luxembourg, Portugal, Romania, USSR and Yugoslavia not being included at this time), the cumulative total of cases increased from 940 to 2 477 in the period from March 1985 to March 1986, representing an overall increase of 163%. Of the 2 542 cases reported up to the end of March 1986, 512 new cases were notified by the 23 countries reporting at the end of December 1985 (data from GDR, Israel and Romania being excluded from this figure), i.e. an average of 39 new cases per week. The countries with the greatest increases were the Federal Republic of Germany, France and Italy, there being an average of 6 to 11 new cases per week.

Clinical Pictures

Table 2 summarises the clinical pictures of the AIDS cases in Europe. At the end of March 1986, 1 308 (51.5%) of the 2 542 AIDS cases reported had died.

Table 2. The clinical pictures of 2 542 AIDS cases reported up to 31 March 1986.

	One or more opportunistic infections	Kaposi's sarcoma	Opportunistic infections and Kaposi's sarcoma	Other*	Total
Number of cases	1 704	467	311	60	2 542
Deaths (%)	56	29	60	63	51.5

* Diagnoses included progressive multifocal leukoencephalopathy, brain lymphoma or non-Hodgkin's lymphoma.

Geographical Origin

Of the 2 542 cases reported in the European Region, 380 occurred in persons of other geographical origin. Most of these cases were from Africa (177 cases) and the Americas (124 cases). Some patients (153) came to Europe after the appearance of the first symptoms.

Distribution by Sex, Age and Risk Group

Males accounted for over 90% of the cases reported in Europe and 64% of the cases of known age group were adults aged 20-49 years. Information on risk groups was available for 2 131 of the 2 542 cases. Of these, 1 579 (74%) were homosexuals or bisexuals, 238 (11%) were heterosexual drug abusers and 47 (2.2%) were homosexual drug abusers. Ninety of the cases were haemophiliacs and 45 had blood transfusion as the only risk factor. No risk factor was found in 6% (132) of the cases compared with 68% for the 288 cases in non-Europeans for whom the risk group had been assessed.

Male homosexuals accounted for 60-95% of the total number of cases in 10 of the 17 countries reporting more than 5 AIDS cases. Cases not belonging to any identified risk group comprised the second largest category. This was particularly marked in Belgium, France and Switzerland where a high proportion of patients originated from regions where AIDS occurs outside the major risk groups.

Drug addiction was the only risk factor for cases reported from 9 countries. Italy and Spain together accounted for 56% of the cases reported among heterosexual drug addicts in March 1985 and for 72% in March 1986. For Europe as a whole, the number of cases in the drug abuser risk group increased from 25 cases (declared by 7 countries) at the end of March 1985 to 240 cases (declared by 9 countries) at the end of March 1986. The proportion of the total number of AIDS cases comprised by drug abusers increased from 3% at the end of 1984 to 10% at the end of March 1986.

Most (65%) of the 66 cases in children under 15 years of age for whom the risk factor had been assessed had parents who either had AIDS or belonged to a high-risk group; 22 paediatric cases were linked to contaminated blood or blood products and 1 was not attributed to any risk factor.

TETANUS IN CANADA

(Based on Disease Surveillance Vol. 7/No. 7, 30 June 1986)

Two cases of clinical tetanus were recently reported in British Columbia, Canada.

Case 1. In October 1985 a 32 year old male presented at the outpatient department of a hospital in Cassiar, B.C. with spasms, difficulty with talking, slurred speech and feeling faint. He had first experienced these symptoms a few hours earlier and history taking revealed a minor laceration from falling and bumping his elbow one week previously. He had also bumped his left leg. His last tetanus immunisation had been at age 15 years while still at school.

Tetanus diagnosis was considered when the patient was noted to have sudden bouts of tensing his whole body. His blood pressure was normal, and routine examination showed no abnormalities apart from a tense abdomen. However treatment for tetanus was initiated.

Fearing a deterioration of vital signs following the sudden onset of the illness, the patient was airlifted to a major regional hospital accompanied by an anaesthetist. During the journey the patient did not require intubation but suffered several bouts of muscle spasms. He was treated with diazepam, Tetanus Immune Globulin (3000 IU), tetanus toxoid and antibiotics. The patient remained in hospital for the next three days for exploration and debridement of this minor laceration.

On follow up in April 1986 the patient recalled episodes of painful muscle spasms of thirty seconds duration. Initially these spasms were occurring hourly but the time intervals increased gradually and the symptoms disappeared over a three week period. Final clinical re-evaluation diagnosed the case as tetanus modified by Tetanus Immune Globulin and toxoid.

Case 2. On 4 April 1986 a 23 year old male consulted his doctor about his difficulty in talking. The patient had a definitè trismus and complained of a disturbing, uneasy feeling in the mouth. He appeared jumpy, jittery and generally feeling unwell. His most recent injuries included:-

- a cut made on his tongue while drinking from a bottle of alcoholic beverage one week previously
- a cut on his left thigh made with a power saw 3 weeks earlier. He had cleaned the wound himself and had not sought medical attention. The saw had been dirty with grease and grime.

After examination he was admitted to hospital and Tetanus Immune Globulin (500 IU) and Tetanus Toxoid 1 mL were given intramuscularly. Intravenous tetracycline 550 mg was administered 6 hourly for 3 consecutive days. Oral medications included diazepam 5 mg 6 hourly and phenobarbital 60 mg 8 hourly. He had fully recovered 5 days later.

A review of the case indicated that the patient was either partially immunised or had a waning immunity in the past 10 years.

CDI Editorial Comment

These two cases highlight the need to consider tetanus in the differential diagnosis of any patient presenting with signs of neuromuscular dysfunction. An immunisation history should be taken and the patient questioned as to any injuries, however minor, received in the previous few weeks.

Tetanus is a notifiable disease in all States and Territories of Australia, and should be reported by the attending medical practitioner to the local health authority. The numbers of cases reported to the Commonwealth Department of Health in recent years are shown below. The true incidence is probably greater than the data would indicate, due to under reporting.

Table 1. Cases of Tetanus notified for the years 1980-1985

Year	1980	1981	1982	1983	1984	1985
No of Cases	9	12	12	10	7	10

The National Health and Medical Research Council recommends that infants and children be immunised against tetanus according to the following schedule:-

(i) at 2, 4, 6 and 18 months immunisation against tetanus is effected by intramuscular administration of Triple Antigen vaccine.

(ii) at 5 years or prior to school entry, a booster effect is elicited by intramuscular administration of Combined Diphtheria - Tetanus (CDT) vaccine.

(iii) at 15 years or prior to leaving school, another booster is effected by the intramuscular administration of Adult Diphtheria-Tetanus (ADT) vaccine.

(iv) immunity thereafter should be maintained by administering boosters at 10 year intervals using either tetanus vaccine or Adult Diphtheria-Tetanus (ADT) vaccine injected intramuscularly, the latter now considered more appropriate to also maintain diphtheria immunity.

Human tetanus immunoglobulin should be considered in the management of tetanus-prone wounds when there is doubt that active immunisation has been carried out.

Whatever the patient's immune status, local disinfection and, where appropriate, surgical treatment must never be omitted. The use of antibiotics for preventing infection is a matter for clinical judgement, but for the specific prevention of tetanus, tetanus immunoglobulin should be regarded as essential.

In partially immune or non-immune subjects, 250 units of human tetanus immunoglobulin is given as soon as practicable after the injury. If more than 24 hours have elapsed 500 units should be given. Tetanus toxoid is given at the same time, in the opposite arm with a separate syringe, arrangements then being made to complete the full course of vaccinations. Human tetanus immunoglobulin should be considered for any tetanus-prone wound. For wounds not in these categories, such as trivial clean cuts treated appropriately, human tetanus immunoglobulin should not normally be given.

Precautions and contraindications

In the event of a previous severe reaction, the need for further tetanus vaccine or ADT should be carefully assessed. In the event of a tetanus-prone wound occurring in an individual who previously suffered a severe reaction to tetanus vaccine, other measures including the use of human tetanus immunoglobulin can be considered.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD 5/8/86 - 18/8/86 BULLETIN NUMBER 86/17

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	5	1	9	1	2	2	10		30
0101 ADENOVIRUS TYPE 1				2		1		4	7
0102 ADENOVIRUS TYPE 2				1		1			2
0103 ADENOVIRUS TYPE 3				1		1			2
0105 ADENOVIRUS TYPE 5				2		3			5
0106 ADENOVIRUS TYPE 6						2			2
0111 ADENOVIRUS TYPE 11	1			1					2
0113 ADENOVIRUS TYPE 13		1							1
0119 ADENOVIRUS TYPE 19								1	1
0126 ADENOVIRUS TYPE 26				1					1
0128 ADENOVIRUS TYPE 28	1								1
0199 ADENOVIRUS TYPING PENDING		1			5				6
0201 INFLUENZA A VIRUS			1						1
0203 INFLUENZA B VIRUS								1	1
0301 PARAINFLUENZA VIRUS TYPE 1				1		2	3	3	9
0302 PARAINFLUENZA VIRUS TYPE 2		1		3	6	18	1	1	30
0303 PARAINFLUENZA VIRUS TYPE 3	1			2	1	2	2		8
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	40	38	11	32	53	4	57	6	241
0500 RHINOVIRUS (ALL TYPES)	1		1	9	12	7	3	3	36
0600 MYCOPLASMA PNEUMONIAE	3	1		5		1	3		13
0700 ORNITHOSIS-PSITTACOSIS				2		2			4
0906 COXSACKIEVIRUS B6						1			1
1002 ECHOVIRUS TYPE 2						1			1
1004 ECHOVIRUS TYPE 4								1	1
1006 ECHOVIRUS TYPE 6						1			1
1007 ECHOVIRUS TYPE 7	1							1	2
1011 ECHOVIRUS TYPE 11	1	2		1				3	7
1014 ECHOVIRUS TYPE 14						1			1
1016 ECHOVIRUS TYPE 16						1			1
1019 ECHOVIRUS TYPE 19		1							1
1020 ECHOVIRUS TYPE 20	1								1
1025 ECHOVIRUS TYPE 25								1	1
1100 POLIOVIRUS NOT TYPED			1						1
1101 POLIOVIRUS TYPE 1				2					2
1102 POLIOVIRUS TYPE 2						3			3
1103 POLIOVIRUS TYPE 3						2		1	3
1200 MUMPS VIRUS				1	1		1		3
1300 HERPES VIRUS GROUP-NOT TYPED	10			2				2	14
1301 HERPES SIMPLEX VIRUS NOT-TYPED				1					1
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	7	1	1	6			5	12	32
1303 VARICELLA-ZOSTER VIRUS	2			1		1		2	6
1306 HERPES SIMPLEX TYPE 1	18		7	33		30	23	34	145
1307 HERPES SIMPLEX TYPE 2	76		27	66		27	59	65	320
1399 HERPES VIRUS TYPING PENDING				3	5				8
1401 COXIELLA BURNETI	1			3			10		14
1502 PICORNA VIRUS-NOT TYPED			13				9	2	24
1521 MEASLES VIRUS						1		1	2
1522 RUBELLA VIRUS				1		3	3	3	10
1532 HEPATITIS B ANTIGEN	27	1	12	15		12	10	13	90
1535 HEPATITIS A ANTIBODY	1			2		17	1	12	33
1541 CHLAMYDIA A - C TRACHOMATIS	32					36		45	113
1543 CHLAMYDIA A - LGV TYPE							2		2
1556 CMV - CYTOMEGALOVIRUS	6		4	18	6	1	29	17	81
1563 CORONAVIRUS								2	2
1564 ROTAVIRUS	29	11	26	17	26	30			139
1571 ENTEROVIRUS TYPE 71 (BRCR)	1	2		6		14			23
1599 ENTEROVIRUS TYPING PENDING		4	6		7				17
9992 ROSS RIVER VIRUS			4				13	2	19
9993 ASTROVIRUS	2								2
9994 SMALL VIRUS (LIKE) PARTICLE		3		1		1			5
9995 DENGUE							1		1
9998 ARBO. GROUP B.							1		1
Total	267	68	123	242	124	229	246	238	1,537

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 5/8/86 - 18/8/86
Viral Identifications by Clinical Information Table 1.
Code 00,99 -No ill or data; 01,02,11,12 -Respiratory; E3 -Enceph-alitis; 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
0100 ADENOVIRUS NOT TYPED.....		1					1				
0101 ADENOVIRUS TYPE 1.....		4					1				1
0102 ADENOVIRUS TYPE 2.....		2									
0103 ADENOVIRUS TYPE 3.....		2									
0105 ADENOVIRUS TYPE 5.....	1	2					2				
0106 ADENOVIRUS TYPE 6.....		1					1				
0111 ADENOVIRUS TYPE 11.....	1									1	
0113 ADENOVIRUS TYPE 13.....											1
0126 ADENOVIRUS TYPE 26.....		1									
0128 ADENOVIRUS TYPE 28.....							1				
0201 INFLUENZA A VIRUS.....		1									
0203 INFLUENZA B VIRUS.....		1							1		
0301 PARAINFLUENZA VIRUS TYPE 1....		8									
0302 PARAINFLUENZA VIRUS TYPE 2....		26			1		2	1			
0303 PARAINFLUENZA VIRUS TYPE 3....		7						1			
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....	9	233		1	1						1
0500 RHINOVIRUS (ALL TYPES).....	1	17		1			1				
0600 MYCOPLASMA PNEUMONIAE.....		12		1							
0700 ORNITHOSIS-PSITTACOSIS.....		3								1	
1002 ECHOVIRUS TYPE 2.....							1				
1004 ECHOVIRUS TYPE 4.....				1							
1006 ECHOVIRUS TYPE 6.....				1							
1007 ECHOVIRUS TYPE 7.....	2										
1011 ECHOVIRUS TYPE 11.....		2		3			1				
1014 ECHOVIRUS TYPE 14.....							1				
1016 ECHOVIRUS TYPE 16.....				1							
1019 ECHOVIRUS TYPE 19.....				1							
1020 ECHOVIRUS TYPE 20.....		1									
1101 POLIOVIRUS TYPE 1.....		2									
1102 POLIOVIRUS TYPE 2.....		2									
1103 POLIOVIRUS TYPE 3.....	1						2				
1200 MUMPS VIRUS.....		2		1							
1300 HERPES VIRUS GROUP-NOT TYPED..	1										2
1301 HERPES SIMPLEX VIRUS NOT-TYPED			1								
1302 EPSTEIN-BARR VIRUS (EB VIRUS).	7	3	1			1		1	1		1
1303 VARICELLA-ZOSTER VIRUS.....				1							
1306 HERPES SIMPLEX TYPE 1.....	11	4		2						1	
1307 HERPES SIMPLEX TYPE 2.....	12	1									77
1399 HERPES VIRUS TYPING PENDING...										1	
1401 COXIELLA BURNETI.....	6							1	1		
1502 PICORNA VIRUS-NOT TYPED.....	1	4					16				1
1521 MEASLES VIRUS.....		1									
1522 RUBELLA VIRUS.....	2	2		1							4
1532 HEPATITIS B ANTIGEN.....	23							59			1
1535 HEPATITIS A ANTIBODY.....	6							15			
1541 CHLAMYDIA A - C.TRACHOMATIS...	18										
1556 CMV - CYTOMEGALOVIRUS.....	7	25		2		1	3	2		2	2
1563 CORONAVIRUS.....		1									
1564 ROTAVIRUS.....		2					137				
1571 ENTEROVIRUS TYPE 71 (BRCR)....	1	3		3			1				15
9992 ROSS RIVER VIRUS.....	1										3
9993 ASTROVIRUS.....							2				
9994 SMALL VIRUS (LIKE) PARTICLE...							5				
9998 ARBO. GROUP B.											1
Total.....	111	376	2	20	2	2	178	80	3	6	200

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 5/8/86 -18/8/86
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
0101 ADENOVIRUS TYPE 1.....										1
0103 ADENOVIRUS TYPE 3.....							1			
0119 ADENOVIRUS TYPE 19.....		1								
0301 PARAINFLUENZA VIRUS TYPE 1....								2		
0302 PARAINFLUENZA VIRUS TYPE 2....								1		
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....							1			
0600 MYCOPLASMA PNEUMONIAE.....								1	1	
0700 ORNITHOSIS-PSITTACOSIS.....								1		
0906 COXSACKIEVIRUS B6.....									1	
1011 ECHOVIRUS TYPE 11.....								1		
1025 ECHOVIRUS TYPE 25.....									1	
1102 POLIOVIRUS TYPE 2.....									1	
1200 MUMPS VIRUS.....			1							
1302 EPSTEIN-BARR VIRUS (EB VIRUS).			8	4	2		1	4	6	
1303 VARICELLA-ZOSTER VIRUS.....			1		1					
1306 HERPES SIMPLEX TYPE 1.....	5	32					1		6	
1307 HERPES SIMPLEX TYPE 2.....	1	231								
1401 COXIELLA BURNETI.....					2		2	6		
1502 PICORNA VIRUS-NOT TYPED.....								1		
1521 MEASLES VIRUS.....		1						1		
1522 RUBELLA VIRUS.....			1						3	
1532 HEPATITIS B ANTIGEN.....				1				1	6	
1535 HEPATITIS A ANTIBODY.....								1	11	
1541 CHLAMYDIA A - C.TRACHOMATIS...		95								
1543 CHLAMYDIA A - LGV TYPE.....	1	1								
1556 CMV - CYTOMEGALOVIRUS.....		6		2		8	1	4	17	2
1563 CORONAVIRUS.....	1							1		
1564 ROTAVIRUS.....									2	
9992 ROSS RIVER VIRUS.....					14			7		
9995 DENGUE.....					1			1		
9998 ARBO. GROUP B.					1					
Total.....	8	367	11	7	21	8	7	33	55	3