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Communicable Diseases Intelligence

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VIRUS REPORTING SCHEME - Fewer reports (962) were processed for this period as the cut-off time was brought forward because of the Easter break.

Five cases of Sudden Infant Death Syndrome were reported by the Royal Children's Hospital, Parkville, Victoria. In two, males aged one and 4 months, enterovirus of undetermined type was isolated, whilst in the other three, (a five month old and 2 three month old females), an untyped poliovirus was isolated.

Five cases of Q fever were reported; two were South Australian shearers, one was a Queensland dairy farmer and in the other two cases (also from Queensland), detailed patient history, including occupational exposure, was not available.

A case of Dengue fever (serotype 4) was reported by the State Health Laboratory, Brisbane in a patient who had recently returned from the Philippines. Three other reported cases were due to serotype 1.

A 50 year old woman from Mackay who presented with arthritis and headache, was found to have serology consistent with active Kunjin virus infection.

Chlamydia psittaci was reported in three bird fanciers - a 68 year old male who presented with atypical pneumonia, a 36 year old female who presented with meningism and atypical pneumonia, and a 44 year old male who presented with fever and malaise.

NEW CDI EDITOR

Up until 25 February 1985, the Editor of the CDI has been Dr Jeffrey Lake. The Editor is now Dr Ian Cook, Director, Epidemiology and Preventive Medicine Section. Enquiries previously directed to Dr Lake should now be made to Dr Cook on 062-898792, or at the address below.

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PROSPECTIVE EVALUATION OF HEALTH-CARE WORKERS EXPOSED VIA THE PARENTERAL OR MUCOUS-MEMBRANE ROUTE TO BLOOD OR BODY FLUIDS FROM PATIENTS WITH ACQUIRED IMMUNODEFICIENCY SYNDROME - UNITED STATES (from MMWR (1985) 34 : 101-3)

On 15 August, 1983, CDC initiated prospective surveillance of health-care workers (HCWs) with documented parenteral or mucous-membrane exposure to potentially infectious body fluids from patients with definite or suspected acquired immunodeficiency syndrome (AIDS). As of 31 December, 1984, 361 HCWs with such exposures were enrolled in CDC's surveillance registry under the auspices of participating hospitals, other health-care institutions, and state and local health departments in the United States. Each enrolled HCW is followed for 3 years with a semiannual interview, physical examination, and blood specimen collection. None of the HCWs have developed signs or symptoms suggestive of AIDS; 143 (40%) have now been followed for 12 months or longer.

Exposed HCWs have been reported from 33 states and the District of Columbia. Fifty-nine percent of the HCWs were reported from six states: New York (61), California (39), New Jersey (36), Pennsylvania (28), Florida (25), and Texas (23). As of 31 December, 1984, the length of follow-up of HCWs ranged from 1 month to 45 months (mean 11 months; median 10 months). Two hundred and eight (58%) HCWs were nurses; 66 (18%), physicians or medical students; 31(9%), laboratory workers; 26 (7%), phlebotomists; 15 (4%), respiratory therapists; and the remaining 15 (4%) had less direct patient contact. Eighty-five percent were white, and 78% were female. Ages ranged from 18 years to 62 years (mean 33 years).

The majority of exposures occurred in direct patient-care areas; 187 (52%) occurred in patients' rooms or on the wards: 99 (27%), in intensive-care units; and seven (2%), in emergency clinics. Thirty-two (9%) incidents took place in laboratories, and 36 (10%) occurred in operating or procedure rooms and morgues. The types of exposures were: needlestick injuries (68%); mucosal exposures (13%); cuts with sharp instruments (10%); and contamination of open skin lesions with potentially infected body fluids (9%). Eighty-eight percent of the exposures were to blood or serum; 6%, to saliva; 2%, to urine; and the remaining 4%, to other body fluids or unknown sources. Postexposure care varied considerably. Forty-eight percent of exposed HCWs received either no specific treatment or local wound care only, while 35% received immune globulin either alone or in combination with other treament.

Complete epidemiologic data have been collected on 226 of the patients to whom these HCWs were exposed. Two hundred and nine (92%) were AIDS patients meeting the CDC surveillance definition, and 17 (8%) were suspected AIDS cases. Two hundred and three (97%) of the 209 AIDS patients were in an identified risk group for acquiring AIDS. The distribution of the AIDS cases by disease category included: Pneumocystis carinii pneumonia (PCP), 62%; Kaposi's sarcoma (KS), 12%, both KS and PCP, 5%; and other opportunistic infections, 21%.

Tests for T-cell subsets have been performed at CDC on blood specimens from 269 (75%) of the exposed HCWs. The mean T-helper/T-suppressor (Th/Ts) ratio for the initial whole blood sample from these HCWs was 2.2 with a range of 0.4-5.4 (normal

range 1.0-3.9). One hundred and eighty-three (68%) of these initial blood specimens were obtained within 180 days from the dates of exposures. Six-month and 12-month follow-up Th/Ts ratios were performed on 69 and six of these 269 HCWs, respectively. All Th/Ts ratios on follow-up specimens were within the normal range, including those from nine HCWs whose initial ratios were less than 1.0.

Serologic testing using the enzyme-linked immunosorbent assay(1) and the Western blot technique(2) for antibody to the human T-lymphotropic virus type III (HTLV-III) has been done, with specific informed consent, on 40 HCWs enrolled in the surveillance system. The mean duration between the date of exposure and the latest serum sample tested was 10.5 months (range 0-29 months; median 8.5 months). The types of exposures included: needlestick injuries (29), cuts with sharp objects (5), mucosal exposures (five), and contamination of open skin lesions (5). None of the HCWs tested were HTLV-III antibody positive. However, with a sample size of 40, the upper limit of the 95% confidence intervals for this incidence of seropositivity (0%) is 7%.

MMWR EDITORIAL COMMENT

Because HTLV-III can be transmitted among intravenous drug abusers by sharing needles and through transfusion of blood and blood products, there is concern that HTLV-III could be transmitted to HCWs by unintentional needlestick or other parenteral or mucous-membrane exposures. A recent report describes an HCW in England who is believed to have developed HTLV-III antibody following parenteral exposure to the blood of an AIDS patient.(3) The HCW reportedly had none of the recognized risk factors for AIDS and remains asymptomatic.

To date, there are no reported cases of AIDS among HCWs in the United States that can be linked to a specific occupational exposure. Of the 8,218 AIDS patients reported to CDC as of 11 February, 1985, 278 (3%) have been HCWs. All but 24 (9%) of these HCWs belong to known AIDS risk groups. Epidemiologic investigations have been completed on 17 of these 24 HCWs; four are currently under investigation, and three died before investigations were completed. In six of the 17 completed investigations, nonoccupational exposures were the most likely sources of infection. No known risk factors for infection were identified in the remaining 11 patients; however, specific occupational exposures to definite or suspected AIDS patients could not be documented.

In December 1984, CDC began testing sera from HCWs enrolled in the surveillance system for antibody to HTLV-III. Testing was performed only with the specific informed consent of enrolled personnel and the agreement of cooperating investigators. Initial results from this analysis and from other similar investigations(4) suggest the risk of transmission of HTLV-III infection from AIDS patients to HCWs may be very small. Thus, to accurately determine the true risk of transmission of HTLV-III from AIDS patients to HCWs, large cohorts of exposed HCWs must be studied. Additional studies with larger cohorts of HCWs are in progress, and CDC will continue immunologic and serologic testing of HCWs from whom institutional investigators have obtained informed consent.

Studies of seroprevalence of HTLV-III among exposed HCWs are of great value from an epidemiologic perspective. However, serologic testing of asymptomatic HCWs for HTLV-III antibody should be done only with informed consent, and a mechanism should exist for transmitting the test results to the HCW in an appropriate manner. The U.S. Public Health Service has developed specific recommendations for individuals, within or outside known risk groups for AIDS, who test positive for HTLV-III antibody.(5,6,7) Health-care professionals should become familiar with and consider these recommendations when serologic testing of asymptomatic HCWs for HTLV-III antibody is contemplated.

Until additional data are available, HCWs should continue to follow previously published precautions when caring for persons with definite or suspected AIDS or when handling specimens from these patients.(8,9)

REFERENCES

1. Getchell, J.P., Kalyanaraman V.S. Unpublished data
2. Methods Enzymol. (1983) 92 : 377-91
3. Lancet (1984) 1 : 1376-7
4. N. Engl. J. Med. (1985) 312 : 1-4
5. MMWR (1983) 32 : 101-3
6. MMWR (1984) 33 : 377-9
7. MMWR (1985) 34 : 1-5
8. MMWR (1982) 31 : 577-80
9. MMWR (1983) 32 : 450-1

CDI EDITORIAL COMMENT

Infection control guidelines for preventing AIDS in health-care workers have been published by the National Health and Medical Research Council.(1) The recommendations are designed to minimise the risk of mucosal or parenteral exposure to potentially infectious material from AIDS patients.

REFERENCE

1. Infection Control Guidelines - Acquired Immune Deficiency Syndrome (AIDS), and conditions which may be related to it. National Health and Medical Research Council, October 1983.

ACQUIRED IMMUNE DEFICIENCY SYNDROME STATISTICS

(1) AUSTRALIA

To 18 March 1985, 61 cases of AIDS, fulfilling the criteria of case definition have been reported to the AIDS Task Force.

States	Cases	Deaths
New South Wales	43	9
Victoria	11	7
Queensland	5	4
Western Australia	2	-
Total	61	20

(2) UNITED KINGDOM

To 28 February, 1985

	Cases	Deaths
	132	58

(from CDR 85/09)

(3) EUROPE

To 31 December 1984

	Cases	Deaths
Austria	13	no breakdown of deaths by country of origin
Belgium	65	
Czechoslovakia	-	
Denmark	34	
Finland	5	
France	260	
Germany, Federal Republic of	135	
Greece	6	
Iceland	-	
Italy	14	
Netherlands	42	
Norway	5	
Poland	-	
Spain	18	
Sweden	16	
Switzerland	41	
United Kingdom	108	
Total	762	376

(from WER (1985) 60)

(4) UNITED STATES OF AMERICA

To 18 February 1985, 8495 cases had been reported to the Centers for Disease Control, Atlanta (from CDR 85/09)

ASPERGILLUS SEROLOGY - DETECTION OF ANTIBODY TO SEVERAL SPECIES

(Contributed by J. Froudist and R. McAleer, Medical Mycology Laboratory, State Health Laboratory Services, Western Australia, P.O. Box F312 G.P.O. Perth W.A. 6001.)

Members of the genus *Aspergillus* may be implicated in a variety of clinical forms of disease, and this has been well described in the literature [1,2]. Antibody to *Aspergillus* is rarely encountered in sera from healthy persons, and the usefulness of serologic tests for antibody in the diagnosis of aspergillosis is well established [3]. *Aspergillus fumigatus* is the species most frequently encountered, and most laboratories test only for antibody to this species. Infections by other species are not uncommon, however, and it has been shown that detection of antibody to *Aspergillus* is improved by the use of antigenic extracts from a battery of *Aspergillus* species [4]. All sera received by the Medical Mycology Laboratory (W.A. State Health Laboratory Services) are routinely tested for antibody against

A. fumigatus (two strains), A. niger, A. flavus and A. terreus, using the Immunodiffusion (I.D.) Test. Between mid-1978 and mid-1984, a total of 2862 sera were tested for antibody to Aspergillus, and the results are summarised in the following table:

Immunodiffusion result	Proportion	Percentage
Total positive	688/2862	24%
Total negative	2174/2862	76%
A.fumigatus only positive	255/688	37%
A.fumigatus positive, at least one other species positive	242/688	35%
A.fumigatus negative, at least one other species positive	172/688	28%

It can be seen that 24% of all sera were positive for antibody to at least one Apergillus species. Twenty eight percent of the positive sera were only positive for antibody to species other than A.fumigatus. This is a significant proportion, and confirms that extracts from a range of species should be used to achieve satisfactory screening for antibody to Aspergillus.

References

1. Am. Rev. Resp. Dis. (1975) 112: 799-805
2. Clin. Allergy (1971) 1 : 261-286
3. Appl. Microbiol. (1972) 23: 301-308
4. Am. Rev. Resp. Dis. (1976) 114: 325-331

OUTBREAK OF SALMONELLA TYPHIMURIUM PHAGE TYPE 135 IN NEW SOUTH WALES

(Contributed by J. Taplin, Microbiological Diagnostic Unit (MDU), University of Melbourne)

Since Christmas 1984 there has been a sudden rise in human isolations of S. typhimurium phage type 135 in NSW. From the beginning of December to the week ending December 23 there were 6 isolations of S. typhimurium 135 in NSW. In the final week of December there were 10 isolations; then the numbers rose to 34, 47, 57 and 43 respectively in the following four weeks in January. Corresponding figures for the isolation of S. typhimurium 135 in NSW in January and February 1983 are a total of 8 in January and 8 in February. In all there have been 220 isolations in NSW from the beginning of December to the end of February.

Isolations in other states have been as follows:

Table 1.

	TOTAL	DECEMBER	JANUARY	FEBRUARY
VIC	10	4	3	3
QLD	4	1	3	-
SA.	7	5	2	-
NT.	1	1	-	-
WA.	28	28	-	-
TAS.	4	3	1	-
NSW.	220	16	181	23
TOTAL	274	58	190	26

The high number of isolations in WA is due to a food poisoning outbreak traced to a turkey dinner.

A total of 133 (59%) of the isolations have been from children under 5, 11% from children aged 6 to 10 years and 11% from adults over 20. No age was given for 16 of the isolates.

Table 2. S. TYPHIMURIUM 135. N.S.W.

Week End.	TOTAL	<1yr	1-5	6-10	11-15	16-20	21-60	>60	U.
Dec 2,	1			1					
Dec 9	4	1	1				1	1	
16	1		1						
23	0								
30	10		3	2	1	1		1	2
Jan 6	34		17	3	1	2	5	2	4
13	47		32	3	1	2	5	2	2
20	57	1	35	7	2	1	5	2	4
27	43	1	27	6	2		6		1
Feb 3	9		5	1		1	1		1
10	8	1	3	1			2		1
17	5		4						1
24	1		1						
TOTAL	220	4	129	24	7	7	25	8	16

Four isolations have been made from blood culture:-

1. from a 42 year old male alcoholic with acute renal and respiratory failure.
2. from a 57 year old male.
3. from a 30 year old female with diarrhoea.
4. from a 74 year old male hypotensive patient who later died.

There was one isolation from blood culture from a 67 year old woman in Victoria.

There were 4 families where 2 children were affected in the family.

Cultures of S. typhimurium isolated in January and February are still being received for phage typing.

Investigations are proceeding to discover the cause of the outbreak.

ARBOVIRUS ACTIVITY ALONG THE SOUTH COAST OF NEW SOUTH WALES (1981 - 1984)

(Contributed by T.G. Vale, K.A. McPhie, I.W. Carter, G.S. James, and M.J. Cloonan, Department of Microbiology, Prince Henry Hospital, Sydney)

We have reported previously [1, 2, 3] that Ross River virus (RRV) was active during 1981-1982 along the south coast of New South Wales. RRV infections in both patients and blood donors from the south coast have also been demonstrated by us during 1983 and 1984. These infections were confirmed by the detection of RRV IgM antibodies using enzyme-linked immunosorbent assay based on antibody class capture [4]. Most of the patients and blood donors had remained within the south coast in the period during which they acquired RRV infection or during which their seroconversion occurred. Recurrent RRV activity has been reported on the mid-north coast of New South Wales in the Port Stephens area [5,6] and now clearly occurs on the south coast as well, particularly in the Nowra and Batemans Bay areas.

Mosquitoes were collected during the summer-autumn period of each year and processed for virus isolation. Collecting sites were in widely separated forests between Nowra and south of Eden. The viruses isolated are summarized in Table 1. RRV was isolated from a pool of *Coquilletidia linealis*, Trubanaman virus from *Coq. linealis* and *Anopheles annulipes*, and Barmah Forest virus from *Aedes vigilax* and a pool of *Coq. linealis*, *Culex molestus* and *C. cylindricus*. The unidentified viruses were recovered from *Ae. cylindricus*. The unidentified viruses were recovered from *Ae. vigilax, C. annulirostris*, and from pools of up to six different mosquito species. Immunofluorescence tests were performed on the six unidentified viruses and were negative for the following groups: alphavirus, flavivirus, bovine ephemeral fever, simbu and bluetongue (J. Shorthose and G. Gard, A.L. Rose Virology Laboratory, Darwin). Microneutralization tests were also negative for the Mapputta group. In addition, none of these unidentified viruses were serologically related to Termeil virus, the only other virus which has been recovered from mosquitoes collected on the south coast of New South Wales[7].

TABLE 1 VIRUSES ISOLATED FROM MOSQUITOES COLLECTED ON THE SOUTH COAST OF NEW SOUTH WALES (1981 - 1984)

YEAR	VIRUS	NUMBER OF ISOLATES
1981	Trabanaman	1
	Unidentified	1
1982	Trubanaman	4
	Ross River	1
	Unidentified	4
1983	Unidentified	1
1984	Barmah Forest	3

The isolation of Trubanaman and Barmah Forest viruses has not been reported previously for coastal New South Wales and together with the recovery of RRV, both in 1972[7] and 1982[3], Termeil virus[7], and the six unidentified viruses indicate a considerable degree of arbovirus activity along the south coast.

The possibility that some or all of these viruses may infect man is of obvious importance and preliminary results from serological tests show that both Trubanaman and Barmah Forest viruses infect man. With the latter, 3% of sera from 300 south coast blood donors were antibody positive, when tested by micro-neutralization, with titres ranging from 1/40 to 1/5120.

References

1. CDI (1981) 81/19:6
2. Aust. J. Exp. Biol. Med. Sci. (1982) 60:701
3. CDI (1982) 82/25:3
4. Pathology (1985) (in press)
5. Am. J. Trop. Med. Hyg. (1973) 22:543
6. Am. J. Trop. Med. Hyg. (1973) 22:551
7. Aust. J. Exp. Biol. Med. Sci. (1980) 58:91

ANNOUNCEMENT - FIRST INTERNATIONAL SEMINAR ON DENGUE HAEMORRHAGIC FEVER IN THE AMERICAS TO BE HELD AT THE DUPONT PLAZA HOTEL, SAN JUAN, PUERTO RICO, JUNE 14-16, 1985

SPONSORS: The seminar is sponsored by the Puerto Rico Department of Health, the Pan American Health Organization and the Centers for Disease Control.

PROGRAM: The purpose of the seminar is to increase awareness in the medical communities and among health officials in the American region, to the potential threat of epidemic dengue hemorrhagic fever, to acquaint them with current methods of diagnosis and treatment of the disease, and to emphasize the need to implement prevention and control measures in the region. The program presentations will be by invitation only, and will deal with clinical diagnosis and treatment, pathophysiology, pathogenesis, vaccines, laboratory diagnosis, surveillance, prevention and control. Invited speakers are all experts in their field and include Drs. R. Carlson, S. B. Halstead, K. M. Johnson, C. Dotres, S. Nimmanitya, C. Ramírez Ronda, J. E. Rhode, L. Rosen, P. K. Russell, Sumarmo. The conference chairman is Dr. D. J. Gubler, Chief, Dengue Branch and Director, San Juan Laboratories, Centers for Disease Control. Members of the program and conference committee are R. H. BermUdez, M.D., A. Casta, R. M. de Andino, M.D., G. Kuno, Ph.D., C. León Valiente, M.D., R. J. Mayoral, Atty., R. Miranda Franco, T. P. Monath, M.D., R. J. Novak, Ph.D., F. Pinheiro, M.D., C. M. Ramírez Ronda, M.D., G. E. Sather, H. Stubbe, M.D.

SCHEDULE:

Day	Event	Time
Friday, June 14	Registration	2:00 - 7:00 p.m.
	Social	7:00 - 9:00 p.m.
Saturday, June 15	Opening Ceremony	8:00 - 9:00 a.m.
	Clinical diagnosis & treatment of DHF	9:00 a.m. - 5:00 p.m.
	Social	7:00 - 11:00 p.m.
Sunday, June 16	Pathogenesis of DHF	8:00 - 11:00 a.m.
	Prevention and control	11:00 a.m. - 4:30 p.m.
	Closing Ceremony	5:00 p.m.

REGISTRATION: A fee of $25 U.S. will be charged each participant who registers in advance. After May 15, the registration fee will be $30 U.S. Instructions for advance registration and hotel reservations will be mailed in late February. Checks should be made out to DHF Conference Committee.

CONFERENCE HOTEL: Dupont Plaza - Tel. (809)724-6161

Conference Rates

Single	Double
U.S.$55	$55

Inquiries regarding the seminar should be addressed to:

Duane J. Gubler, Sc.D.
Chief, Dengue Branch and
Director, San Juan Laboratories
Centers for Disease Control, CID
G. P. O. Box 4532
San Juan, PR 00936

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD - 14/3/85 – 27/3/85 BULLETIN NUMBER 85/7

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			3	1	8	1	14	3	30
0101 ADENOVIRUS TYPE 1				1				1	2
0102 ADENOVIRUS TYPE 2						6			6
0103 ADENOVIRUS TYPE 3						2		2	4
0105 ADENOVIRUS TYPE 5						2		2	4
0107 ADENOVIRUS TYPE 7								1	1
0112 ADENOVIRUS TYPE 12		1							1
0119 ADENOVIRUS TYPE 19								1	1
0137 ADENOVIRUS TYPE 37								1	1
0199 ADENOVIRUS TYPING PENDING					5	3			8
0201 INFLUENZA A VIRUS								2	2
0203 INFLUENZA B VIRUS				2			2		4
0301 PARAINFLUENZA VIRUS TYPE 1					4	2			6
0302 PARAINFLUENZA VIRUS TYPE 2					7	1	1		9
0303 PARAINFLUENZA VIRUS TYPE 3		1	1		2	1		1	6
0399 PARAINFLUENZA VIRUS TYPING PENDING							9		9
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)		2	3	1	5	7	5		23
0500 RHINOVIRUS (ALL TYPES)				1	17	1	2		21
0600 MYCOPLASMA PNEUMONIAE							1	1	2
0700 ORNITHOSIS-PSITTACOSIS				1		2			3
0809 COXSACKIEVIRUS A9					1				1
0903 COXSACKIEVIRUS B3				1					1
0904 COXSACKIEVIRUS B4						1			1
0905 COXSACKIEVIRUS B5					2	2	1		5
1006 ECHOVIRUS TYPE 6						1			1
1007 ECHOVIRUS TYPE 7		1	1				1		3
1009 ECHOVIRUS TYPE 9		1							1
1011 ECHOVIRUS TYPE 11				1					1
1022 ECHOVIRUS TYPE 22					3				3
1030 ECHOVIRUS TYPE 30				1					1
1100 POLIOVIRUS NOT TYPED			2		6		2		10
1102 POLIOVIRUS TYPE 2		1							1
1103 POLIOVIRUS TYPE 3						2			2
1200 MUMPS VIRUS		1				1			2
1300 HERPES VIRUS GROUP-NOT TYPED				5		1	1	2	9
1301 HERPES SIMPLEX VIRUS NOT-TYPED		1		3					4
1302 EPSTEIN-BARR VIRUS (EB VIRUS)		2		6				12	20
1303 VARICELLA-ZOSTER VIRUS			1				1	7	9
1306 HERPES SIMPLEX TYPE 1				33	11	16	30	16	106
1307 HERPES SIMPLEX TYPE 2				57	1	29	65	56	208
1399 HERPES VIRUS TYPING PENDING				1	4	2			7
1401 COXIELLA BURNETI						2	3		5
1502 PICORNA VIRUS-NOT TYPED			4				51	3	58
1521 MEASLES VIRUS				2		1	1	1	5
1522 RUBELLA VIRUS					1	3		2	6
1531 HEPATITIS B VIRUS		2		29		1			32
1532 HEPATITIS B ANTIGEN		1	12		2	30	7	8	60
1535 HEPATITIS A ANTIBODY			1	2		6	2	4	15
1541 CHLAMYDIA A - C TRACHOMATIS			4	43			25	39	111
1556 CMV - CYTOMEGALOVIRUS			2	9	6	5	9	2	33
1564 ROTAVIRUS		1	11		9	14		1	36
1599 ENTEROVIRUS TYPING PENDING			17		9				26
9992 ROSS RIVER VIRUS				2			21	5	28
9994 SMALL VIRUS (LIKE) PARTICLE				1					1
9995 DENGUE							4		4
9997 KUNJIN VIRUS							1		1
9998 ARBO. GROUP B. ...							2		2
Total		15	62	203	103	145	261	173	962

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 14/3/85 to 27/3/85 .... 85/7

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..........	5	5					6				
0101 ADENOVIRUS TYPE 1............							2				
0102 ADENOVIRUS TYPE 2............		3					2				
0103 ADENOVIRUS TYPE 3............		1					1				
0105 ADENOVIRUS TYPE 5............		1				1	2				
0112 ADENOVIRUS TYPE 12...........							1				
0137 ADENOVIRUS TYPE 37...........	1										
0201 INFLUENZA A VIRUS............		2									
0203 INFLUENZA B VIRUS............		3									
0301 PARAINFLUENZA VIRUS TYPE 1....		6					1				
0302 PARAINFLUENZA VIRUS TYPE 2....		9									
0303 PARAINFLUENZA VIRUS TYPE 3....		6									
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)............................		22							1		
0500 RHINOVIRUS (ALL TYPES)........	1	17	1				1				1
0600 MYCOPLASMA PNEUMONIAE.........		3									
0700 ORNITHOSIS-PSITTACOSIS........		2									
0809 COXSACKIEVIRUS A9............		1									
0904 COXSACKIEVIRUS B4............							1				
0905 COXSACKIEVIRUS B5............	1	1		1			1				
1006 ECHOVIRUS TYPE 6.............		1									
1007 ECHOVIRUS TYPE 7.............		2		1							
1009 ECHOVIRUS TYPE 9.............			1								
1011 ECHOVIRUS TYPE 11............				1							
1022 ECHOVIRUS TYPE 22............		1									
1030 ECHOVIRUS TYPE 30............				1							
1100 POLIOVIRUS NOT TYPED..........		2		1			2				
1102 POLIOVIRUS TYPE 2............		1									
1103 POLIOVIRUS TYPE 3............							1				
1300 HERPES VIRUS GROUP-NOT TYPED..											5
1301 HERPES SIMPLEX VIRUS NOT-TYPED											4
1302 EPSTEIN-BARR VIRUS (EB VIRUS).		2						1			
1303 VARICELLA-ZOSTER VIRUS........						1					8
1306 HERPES SIMPLEX TYPE 1.........	5	5	1	2					1	1	[illegible]
1307 HERPES SIMPLEX TYPE 2.........	8										58
1401 COXIELLA BURNETI..............		1						1			
1502 PICORNA VIRUS-NOT TYPED.......		1		2			4				1
1521 MEASLES VIRUS.................											4
1522 RUBELLA VIRUS.................											3
1531 HEPATITIS B VIRUS.............	22							9			
1532 HEPATITIS B ANTIGEN...........	5							33			
1535 HEPATITIS A ANTIBODY..........	1						1	12			
1541 CHLAMYDIA A - C.TRACHOMATIS...							1				
1556 CMV - CYTOMEGALOVIRUS.........	4	12				1		2		2	
1564 ROTAVIRUS.....................				3			31				
1599 ENTEROVIRUS TYPING PENDING....		4	1	5			13				
9992 ROSS RIVER VIRUS..............	2										12
9994 SMALL VIRUS (LIKE) PARTICLE...							1				
9995 DENGUE........................	2										
9998 ARBO. GROUP B.	1										
Total..............................	58	116	4	17		3	72	58	2	3	154

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 14 / 3/85 to 27/ 3 / 85 ...
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 ...

85/7

VIRUS OR VIRAL ANTIGEN	Eye	Genital	Endo/ sal gland	RES	Muscle /joint	Congenital	PUO	Fever /malaise	Other	SIDS
0100 ADENOVIRUS NOT TYPED..........	6		1							
0102 ADENOVIRUS TYPE 2............	1									
0103 ADENOVIRUS TYPE 3............	1						1			
0107 ADENOVIRUS TYPE 7............	1									
0119 ADENOVIRUS TYPE 19...........		1								
0203 INFLUENZA B VIRUS............					2			1		
0302 PARAINFLUENZA VIRUS TYPE 2....								1		
0303 PARAINFLUENZA VIRUS TYPE 3....				1						
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)...........................								2		
0500 RHINOVIRUS (ALL TYPES)........							1		1	
0700 ORNITHOSIS-PSITTACOSIS........								1		
0809 COXSACKIEVIRUS A9............							1			
0903 COXSACKIEVIRUS B3............								1		
0905 COXSACKIEVIRUS B5............									1	
1007 ECHOVIRUS TYPE 7.............							1			
1022 ECHOVIRUS TYPE 22............							1		1	
1100 POLIOVIRUS NOT TYPED..........										3
1103 POLIOVIRUS TYPE 3............									1	
1200 MUMPS VIRUS..................			1					1		
1300 HERPES VIRUS GROUP-NOT TYPED..		1				1				
1302 EPSTEIN-BARR VIRUS (EB VIRUS).			7	2	1		1	4	4	
1306 HERPES SIMPLEX TYPE 1.........	2	29		1				3	5	
1307 HERPES SIMPLEX TYPE 2.........		141							2	
1401 COXIELLA BURNETI.............					1		2	3		
1502 PICORNA VIRUS-NOT TYPED.......								2		
1521 MEASLES VIRUS................					1				1	
1522 RUBELLA VIRUS................			1					1	3	
1531 HEPATITIS B VIRUS............									1	
1532 HEPATITIS B ANTIGEN...........									22	
1535 HEPATITIS A ANTIBODY..........									1	
1541 CHLAMYDIA A - C.TRACHOMATIS...		110								
1556 CMV - CYTOMEGALOVIRUS.........		3		1		2	1		5	
1564 ROTAVIRUS....................							1		1	
1599 ENTEROVIRUS TYPING PENDING....								2		2
9992 ROSS RIVER VIRUS.............					22			7		
9995 DENGUE.......................								2		
9997 KUNJIN VIRUS.................					1					
9998 ARBO. GROUP B.					1					
Total...........................	11	285	10	5	29	3	10	31	49	5