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Communicable Diseases Intelligence

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Contents:

VIRUS REPORTING SCHEME A total of 1275 reports were processed this period. The increased number of returns for influenza A virus (41 reports compared with 26, 14 and 8 for the previous three periods) and the anecdotal reports in the media confirm extensive influenza activity in the community. All age groups are being affected. Of the 41 notifications, 17 were subtyped as H_3N_2, with the 13 strains isolated at the State Health Laboratory, Brisbane, exhibiting some identity with A/Wellington/3/84. All of these influenza A strains, and the seven influenza B isolates were referred from throughout Queensland. The laboratory also isolated the first H_1N_1 strain for 1985, provisionally characterised as A/Chile/1/83-like, from a 12 year old girl. The WHO Influenza Reference Centre, Melbourne, has already isolated eight influenza A strains this month (a total of six were isolated in June). Although considerable drift away from A/Philippines/2/82 has been demonstrated, full analysis has yet to be completed. The strains apparently fall into two streams characterised by the prototypes A/Victoria/3/85 and A/Victoria/101/85 (see CDI 85/12:1). A complete HI characterisation of these strains will be published in a future issue. The clinical presentations of the 14 influenza A reports from the State Health Laboratory Services, Perth, apart from the typical symptoms of headache, fever, abdominal pain and vomiting, included three adults with asthma, an 83 year old male with myocarditis/endocarditis, a 42 year old male and a 3 year old girl with haematuria, and a 64 year old male with Guillain-Barré syndrome.

. Echovirus type 7 continues to be the most prevalent enterovirus reported this year, with 12 reports compared with 19, 19 and 43 for the previous three periods. Only 29 reports were recorded in 1984, although of the 34 serotypes of echovirus, type 7 was the fifth most common cause of infection in children reported to WHO during 1967-1974. The virus is usually associated with asymptomatic infection in young children, with neurological, respiratory, and gastrointestinal involvement being the most common clinical presentations. Maculopapular rashes are common, although some outbreaks have exhibited a noted absence of skin involvement (CDS (1985) 85/10). The lack of haemagglutinin activity appears to be characteristic of the more virulent echovirus type 7 strains.

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TRAVELLERS' DIARRHOEA (TD)

Three hundred million people travel internationally each year; in the 12 million people from highly industrialised nations travelling to developing countries[1], diarrhoea is the most frequently encountered health problem[2].

To resolve many of the questions of TD, the National Institutes of Health Office of Medical Applications of Research and the National Institute of Allergy and Infectious Diseases convened a Consensus Development Conference on Travellers' Diarrhoea from 28-30 January 1985[3].

TD is usually regarded as a syndrome characterised by two or more loose stools occurring in a 24 hour period with onset more than 24 hours after a person's arrival in unfamiliar territory, and accompanied by at least one of the following; abdominal cramps, tenesmus, vomiting, fever and chills, and prostration[4]. TD is usually an acute, short-lived condition. The median duration of diarrhoea is 3-4 days, although travellers may experience more than one attack of TD during a single trip. Persistent diarrhoea is uncommon and may differ considerably from acute TD with respect to aetiology and risk factors. TD is rarely life-threatening.

The most important determinants of risk of TD are the destination of the traveller, and what they eat and drink. Recent data on attack rates are available from relatively few countries, with the best estimates reported for Swiss travellers[5]. Examples of high-risk destinations include most of the developing countries of Latin America, Africa, the Middle East, and Asia. Intermediate-risk destinations include most of the Southern European countries and a few Caribbean islands. Low-risk destinations include Canada, Northern Europe, Australia, New Zealand, the United States, and a number of the Caribbean islands. TD is acquired through ingestion of faecally contaminated food and/or water. Uncooked and improperly handled cooked foods have been implicated in TD. These include salads, raw vegetables, cold platters, custards and pastries; raw shellfish, raw or undercooked seafood or meat dishes; raw eggs, cheese, milk and other dairy products[6].

Although a polymicrobial aetiology is usually associated with TD, enterotoxigenic Escherichia coli (ETEC) is the most common primary agent[7,8]. Other enteric pathogens such as salmonella, shigella, campylobacter, Aeromonas hydrophila, and Giardia lamblia account for 20-30% of the total, and Vibrio cholerae non 01, Plesiomonas shigelloides, rotavirus and Norwalk-like viruses have been detected in less than 5%. Parasitic enteric pathogens such as Cryptosporidium, Entamoeba histolytica, Dientamoeba fragilis, Isospora belli, Balantidium coli or Strongyloides stercoralis may cause occasional cases of TD. Even with the application of the best current methods of detecting bacteria, viruses, and parasites, in various studies 20-50% of cases remain without recognised aetiologies.

PREVENTIVE MEASURES - There are three possible approaches to prevent TD; these include precautions with food and water, use of nonantimicrobial medications, and prophylactic antimicrobial drugs.

Rational precautions with water and such foods mentioned above form the bulwark of prevention, although most travellers have

great difficulty in observing these dietary restrictions, and in one study the recommendations seemed to be unrealistic and unsuccessful[5].

Several nonantimicrobial drugs have been advocated, including Lomotil, Imodium, and bismuth subsalicylate, but none is recommended for prophylaxis either because of lack of efficacy and/or potential for adverse reactions.

Enterovioform and related hydroxyquinoline derivatives are no longer recommended due to their serious adverse neurological reactions. Carefully controlled studies have indicated that two agents - doxycycline[9,10] and trimethoprim - sulphamethoxazole, when taken prophylactically, are consistently effective in reducing the incidence of TD by 50-86% in various parts of the developing world. Prophylactic use of these drugs, however, is not indicated due to their adverse reactions.

TREATMENT MEASURES - Standard treatment consists of abstinence from food with adequate oral replacement of fluids with boiled water and glucose, or bottled soft drinks which have been properly heat-treated during manufacture. If possible, an attempt should be made to identify the active cause of the TD.

Antidiarrhoeal agents may control the symptoms of TD but should not be given to children.

Although clinical trials with antimicrobial agents (trimethoprim-sulphamethoxazole, doxycycline) have shown that these agents can shorten the duration of TD, it must however be emphasised that antimicrobial therapy is seldom indicated for this condition.

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ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) - EUROPE

(Based on WER (1985) 60 : 189-90)

The AIDS epidemic continues to spread in Europe. As of 31 March 1985, 940 cases had been reported to the WHO Collaborating Centre on AIDS in Paris, of which 178 were new cases since 31 December 1984 (Table 1), which represents an average increase of 14 cases per week. The greatest increases in the number of cases were observed in France: 47 new cases (3-4 per week); the United Kingdom: 32 cases (2-3 per week); the Federal Republic of Germany: 27 cases (2-3 per week). An increase of one case per week was noted for Belgium, the Netherlands, Spain and Switzerland; for the other ten countries taking part in the surveillance of AIDS, 0-8 new cases were notified between January and March 1985.

The highest rates per million population were observed in Denmark: 8.0; Switzerland: 7.9; and France: 5.6. These rates are low by comparison with the rate in the United States of America: 40.9 as of 1 April 1985. Belgium is in a special position because 77% of the notified cases are among Africans.

TABLE 1: Total number of AIDS cases reported by 31 March 1985 in 17 European countries and estimated rates per million population

Country	October 1983	October 1984	December 1984	March 1985	Rates
Austria	7	-	13	13	1.7
Belgium	38	-	65	81	8.2
Czechoslovakia	-	-	-	-	-
Denmark	13	31	34	41	8.0
Finland	-	4	5	5	1.0
France	94	221	260	307	5.6
Germany, Federal Republic of	42	110	135	162	2.6
Greece	-	2*	6	7	0.7
Iceland	-	-	-	-	-
Italy	3	10	14	22	0.4
Netherlands	12	26	42	52	3.6
Norway	-	4	5	8	2.0
Poland	-	-	-	-	-
Spain	29	18	18	29	0.8
Sweden	4	12	16	22	2.7
Switzerland	17	33	41	51	7.9
United Kingdom	24	88	108	140	2.5
Total	260	559	762	940	2.4

* Data of 15 July 1984

Deaths

Four hundred and sixty-eight deaths were reported for 940 cases (case-fatality rate: 49.8%). Fifty-two per cent of the cases diagnosed one year ago and 86% of those diagnosed three years ago have died.

Distribution of cases by risk group and geographical origin

There is no change by comparison with the previous report (WER (1985) 60 : 85-90) in the distribution of cases by age, sex or geographical origin (Table 2).

Homosexuals are still the main risk group (70% of cases). However, cases among drug abusers have been notified in seven countries (2.7% of cases as against 1.4% as of 31 December 1984). Furthermore, cases of AIDS associated with the use of blood products have increased (1.7% of cases as against 1.4% as of 31 December 1984). Cases among haemophiliacs were notified in seven countries. These cases represent a significant percentage of the total number of cases notified at national level for some countries: Spain: 21% (6 cases out of 29); Greece: 14% (1 case out of 7); Austria: 8% (1 case out of 13); the Federal Republic of Germany: 7% (11 cases out of 162); Sweden: 5% (1 case out of 22); the United Kingdom: 3% (4 cases out of 140); France: 1% (3 cases out of 307). Among the haemophiliac population of these countries, the number of AIDS cases varies between 1 and 3 per 1 000. These seven

countries have imported blood products from the United States of America in recent years.

TABLE 2: Distribution of AIDS cases by risk group and geographical origin in 17 European countries listed in Table 1, 31 March 1985

Risk group	Geographical origin				
	Europe	Caribbean	Africa	Others	Total
1. Male homosexuals or bisexuals	627	4	9	20	661*
2. I.V. drug addicts	25	-	-	-	25
3. Haemophiliacs	27	-	-	1	28
4. Transfusion recipients (without other risk factors)	11	-	5	-	16
5. Homosexuals/bisexuals + I.V. drug addicts	10	-	-	2	12
6. No known risk factor					
- males	33	20	67	2	122
- females	18	7	32	-	57
7. Unknown	5	1	11	2	19
Total	756	32	124	28*	940

*CDI Editorial Note: These totals are inconsistent with the data in this Table.

Two countries reported cases among persons who had received transfusions of blood from the national blood-donation systems (France: 7; United Kingdom: 1). This shows that the use of local products cannot in itself guarantee the safety of transfusion for European countries in which AIDS foci are developing. Other measures can be taken to improve this safety:

- the preferential use when possible of a cryoprecipitate rather than a concentrate of factor VIII;
- the use of heated products;
- the selection of blood donors having regard to identified risk groups;
- the detection of blood donors who are anti-LAV/HTLV-III antibody carriers.

Lastly, it is important to note that the AIDS cases connected with the transfusion of blood or blood products are essentially due to the dissemination of the virus responsible for the disease in the population. Transmission of LAV/HTLV-III by sexual contact is the main factor in this dissemination at the present time. Health education programmes, more particularly the provision of information to individuals belonging to exposed populations, and the training of health workers in the problems raised by AIDS, are essential elements in the establishment of public health strategies. The choice of these strategies must be made for each country in the light of the particular epidemiological characteristics, socio-cultural conditions and the available resources.

AIDS SURVEILLANCE - JAPAN

(Based on WER (1985) 60 : 202

As of 31 May 1985, six cases of AIDS (including three deaths) had been confirmed by the AIDS Chōsa Kentō Iinkai (Investigation Committee).

Clinical and immunological diagnosis

All six cases are Japanese males (three homosexuals and three haemophiliacs), showing antibody to LAV/HTLV-III and an inversion of the T-helper/T-suppressor cell ratio, as well as presenting some of the clinical signs and symptoms characteristic of AIDS.

Homosexual cases: The first is a 36 year old male who had multiple sexual contacts in Europe and in the United States of America, where he is now residing; the second is a 35 year old male who had an amoebic liver abscess, but has since recovered and is now an out-patient; the third is a 33 year old male with a history of Pneumocystis carinii pneumonia.

Haemophilia patients: All three haemophiliacs had candidiasis. The first (48 years old) died in July 1983; the second (62 years old) died in November 1984; and the third (27 years old) died in April 1985.

LEGIONELLOSIS - STAFFORDSHIRE, ENGLAND AND WAYNE COUNTY, MICHIGAN, USA

(Based on MMWR (1985) 34 : 344 and CDR 85/22

An outbreak of legionellosis occurred during April and early May 1985 in Staffordshire, England. During this period, 158 persons were hospitalised with acute respiratory infections; 36(23%) of these cases have been fatal. To date, 60 patients have laboratory evidence of legionellosis, including 11 of the fatal cases. Patients are predominantly elderly, and most reside within an 8-10 mile area. The only common exposure noted among the 50 confirmed cases was a visit to the Outpatient Department (OPD) at the Stafford District General Hospital. A case-control study to confirm this association and to define specific exposures within the OPD is under way. Most visits to the OPD occurred in the week following Easter vacation. The OPD was not open during the vacation period, and the water supply was not circulating at that time. Samples from the potable water system have been negative for Legionella to date.

There is also a cooling tower from the air conditioning system in the vicinity of the OPD, and L. pneumophila serogroup 1 has been isolated from water samples. The OPD wing, which the patients visited, and the adjacent clinics were ventilated by one trunk of the system. This trunk had on it a cooling unit, chiller battery, beneath which was an enclosed tray to collect condensate from the chiller. The condensate was conveyed away by a pipe through a U-bend trap to a soil stack which also drained the pond of the cooling tower situated in the upper roof plant room. There was no air-break in the pipe between the chiller battery, in the ventilating system, and the soil stack. It has been shown that water discharged down the soil stack from the cooling tower pond entered the ventilating system via the chiller battery drain when the fan in the trunking to the OPD was switched off, as it usually was overnight and at weekends. That is, there was a reverse flow from the dirty soil stack to the clean ventilating system which could have conveyed legionella into the cooling unit on the ventilator trunk to the OPD.

An outbreak of legionellosis also occurred in Michigan USA during early May 1985. Fourteen cases of pneumonia with high

fever have been identified in the approximately 380 persons who attended a church banquet at a hotel on 27 April; three (21%) of these cases have been fatal. To date, seven cases have laboratory evidence of legionellosis, including all the fatal cases. No common exposures other than attending the banquet have been identified. Samples of the hotel's potable water, a nearby swimming pool and whirlpool, and the twelve functioning heat and ventilation air conditioning units have been obtained. Washings obtained from the external surface of the cooling coils of both air conditioning units supplying the banquet hall have grown L. pneumophila serogroup 1. Passive surveillance of the over 800 persons attending 12 other banquets held at the hotel between April 25 and May 10 has identified only one suspected case with pneumonia. No recent cases have been identified.

(continued from page 1)

Four cases of dengue fever were reported by the State Health Laboratory, Brisbane, in the previous period (see CDI 85/13). IgM antibody to dengue type 1 was detected in a 68 year old female from Townsville, to dengue type 2 in a 64 year old male from Brisbane, and cross-reacting IgM to serotypes 1, 2 and 4 in serum referred from a 23 year old male from New South Wales. Dengue type 2 was also diagnosed in a 26 year old female from Brisbane. Specific IgM to Kunjin virus was also detected in a 15 year old boy from Cairns.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD - 20/6/85 - 3/7/85 BULLETIN NUMBER 85/14
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	20	2	2	1	2		15	4	46
0101 ADENOVIRUS TYPE 1		1							1
0102 ADENOVIRUS TYPE 2				1					1
0103 ADENOVIRUS TYPE 3		1	1					2	4
0107 ADENOVIRUS TYPE 7	2								2
0108 ADENOVIRUS TYPE 8	1			2					3
0135 ADENOVIRUS TYPE 35				1					1
0137 ADENOVIRUS TYPE 37								1	1
0199 ADENOVIRUS TYPING PENDING		4		1	3				8
0201 INFLUENZA A VIRUS	6	1	2					14	23
0202 INFLUENZA A VIRUS SUBTYPE H3N2					4		13		17
0203 INFLUENZA B VIRUS	2						6	1	9
0206 INFLUENZA A VIRUS SUBTYPE H1N1							1		1
0301 PARAINFLUENZA VIRUS TYPE 1					1				1
0302 PARAINFLUENZA VIRUS TYPE 2	2				1		2	2	7
0303 PARAINFLUENZA VIRUS TYPE 3	1				5		1	1	8
0399 PARAINFLUENZA VIRUS TYPING PENDING					1				1
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	21	46	3	8	42		17	19	156
0500 RHINOVIRUS (ALL TYPES)	2		1	6	4		1	8	22
0600 MYCOPLASMA PNEUMONIAE	3		2	1				1	7
0700 ORNITHOSIS-PSITTACOSIS	2			4					6
1003 ECHOVIRUS TYPE 3								1	1
1005 ECHOVIRUS TYPE 5				1					1
1007 ECHOVIRUS TYPE 7	6			5				1	12
1017 ECHOVIRUS TYPE 17				1					1
1020 ECHOVIRUS TYPE 20				2					2
1021 ECHOVIRUS TYPE 21								1	1
1100 POLIOVIRUS NOT TYPED			2						2
1101 POLIOVIRUS TYPE 1		1							1
1102 POLIOVIRUS TYPE 2		1		1					2
1103 POLIOVIRUS TYPE 3								2	2
1200 MUMPS VIRUS				2					2
1300 HERPES VIRUS GROUP-NOT TYPED	18			2				3	23
1301 HERPES SIMPLEX VIRUS NOT-TYPED		7		3				3	13
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	7	1	2	4	1			3	18
1303 VARICELLA-ZOSTER VIRUS	6			1			1		8
1306 HERPES SIMPLEX TYPE 1	17		12	23			42	15	109
1307 HERPES SIMPLEX TYPE 2	113		20	63			65	57	318
1399 HERPES VIRUS TYPING PENDING					6			1	7
1401 COXIELLA BURNETI	3			1			1		5
1502 PICORNA VIRUS-NOT TYPED	4		4				7	2	17
1521 MEASLES VIRUS	1			1					2
1522 RUBELLA VIRUS	3			3	1		1	2	10
1532 HEPATITIS B ANTIGEN	56		7	20			5	15	103
1535 HEPATITIS A ANTIBODY	7		1	2	1		1	4	16
1541 CHLAMYDIA A - C TRACHOMATIS	46		5	23 *			2	71	147
1555 PAPOVAVIRUS GROUP (PAPILLOMA-HUMAN WART)				1					1
1556 CMV - CYTOMEGALOVIRUS	14	3	1	12	7		6	10	53
1564 ROTAVIRUS	15	13	6	1	6			8	49
1565 CALICI VIRUS	2								2
1599 ENTEROVIRUS TYPING PENDING			10		7				17
9993 ASTROVIRUS	1			1					2
9994 SMALL VIRUS (LIKE) PARTICLE	2	1							3
Total	383	82	81	198	92		187	252	1,275

* Cultures performed at Microbiological Diagnostic Unit, Melbourne

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 20 / 6 / 85 to 3 / 7 / 85 ....
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.....	6						10	1			
0101 ADENOVIRUS TYPE 1.....		1									
0102 ADENOVIRUS TYPE 2.....		1									
0103 ADENOVIRUS TYPE 3.....		3									
0107 ADENOVIRUS TYPE 7.....		2									
0108 ADENOVIRUS TYPE 8.....	1										
0201 INFLUENZA A VIRUS.....		16			1		1		1	1	1
0202 INFLUENZA A VIRUS SUBTYPE H3N2		17									
0203 INFLUENZA B VIRUS.....		8							1		
0206 INFLUENZA A VIRUS SUBTYPE H1N1		1									
0301 PARAINFLUENZA VIRUS TYPE 1....		1									
0302 PARAINFLUENZA VIRUS TYPE 2....		6									
0303 PARAINFLUENZA VIRUS TYPE 3....		7									
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....	2	150							1		
0500 RHINOVIRUS (ALL TYPES).....	2	16					1				
0600 MYCOPLASMA PNEUMONIAE.....		6							1		
0700 ORNITHOSIS-PSITTACOSIS.....		6									
1003 ECHOVIRUS TYPE 3.....		1									
1005 ECHOVIRUS TYPE 5.....		1									
1007 ECHOVIRUS TYPE 7.....	2	1		3			4				1
1020 ECHOVIRUS TYPE 20.....				1							
1021 ECHOVIRUS TYPE 21.....		1									
1100 POLIOVIRUS NOT TYPED.....							2				
1101 POLIOVIRUS TYPE 1.....		1									
1102 POLIOVIRUS TYPE 2.....		2									
1300 HERPES VIRUS GROUP-NOT TYPED..	4								1		3
1301 HERPES SIMPLEX VIRUS NOT-TYPED		2	2							1	8
1302 EPSTEIN-BARR VIRUS (EB VIRUS).	4	1						2			
1303 VARICELLA-ZOSTER VIRUS.....											6
1306 HERPES SIMPLEX TYPE 1.....	3	6				1	1				49
1307 HERPES SIMPLEX TYPE 2.....	9	2									47
1501 COXIELLA BURNETI.....	1	1									
1502 PICORNA VIRUS-NOT TYPED.....	2						3		1		
1521 MEASLES VIRUS.....											2
1522 RUBELLA VIRUS.....		1									4
1532 HEPATITIS B ANTIGEN.....	66	1						28			
1535 HEPATITIS A ANTIBODY.....	3							13			
1541 CHLAMYDIA A - C.TRACHOMATIS...	1										
1555 PAPOVAVIRUS GROUP (PAPILLOMA-HUMAN WART).....											1
1556 CMV - CYTOMEGALOVIRUS.....	7	15					2	2	2	2	1
1564 ROTAVIRUS.....	1	2				1	40				
1565 CALICI VIRUS.....							1				
9993 ASTROVIRUS.....							2				
9994 SMALL VIRUS (LIKE) PARTICLE...							3				
Total.....	114	279	2	4	1	2	70	46	8	4	123

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 20/6/85 to 3/7/85 ...
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 ...

VIRUS OR VIRAL ANTIGEN	Eye	Genital	Endo/sal gland	RES	Muscle/joint	Congenital	PUO	Fever/malaise	Other	SIDS
0100 ADENOVIRUS NOT TYPED.....								1	6	
0103 ADENOVIRUS TYPE 3.....	1									
0108 ADENOVIRUS TYPE 8.....	2									
0135 ADENOVIRUS TYPE 35.....									1	
0137 ADENOVIRUS TYPE 37.....		1								
0201 INFLUENZA A VIRUS.....								4	1	
0302 PARAINFLUENZA VIRUS TYPE 2....							1			
0303 PARAINFLUENZA VIRUS TYPE 3....									1	
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....		1						5	1	
0500 RHINOVIRUS (ALL TYPES).....								1	2	1
1007 ECHOVIRUS TYPE 7.....							1	4		
1017 ECHOVIRUS TYPE 17.....									1	
1020 ECHOVIRUS TYPE 20.....					1					
1102 POLIOVIRUS TYPE 2.....						1				
1103 POLIOVIRUS TYPE 3.....	-							1		1
1200 MUMPS VIRUS.....			2							
1301 HERPES SIMPLEX VIRUS NOT-TYPED									1	
1302 EPSTEIN-BARR VIRUS (EB VIRUS).			8	1			1		2	
1303 VARICELLA-ZOSTER VIRUS.....	1	1								
1306 HERPES SIMPLEX TYPE 1.....	5	43						2	2	
1307 HERPES SIMPLEX TYPE 2.....	1	259								
1401 COXIELLA BURNETI.....							2	1		
1502 PICORNA VIRUS-NOT TYPED.....					3		1	1		
1522 RUBELLA VIRUS.....			1						5	
1532 HEPATITIS B ANTIGEN.....			1					1	7	
1541 CHLAMYDIA A - C.TRACHOMATIS...		122							2	
1556 CMV - CYTOMEGALOVIRUS.....		5		1		4		2	12	2
1564 ROTAVIRUS.....									4	
1565 CALICI VIRUS.....									1	
Total.....	10	432	12	2	4	5	6	23	49	4