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Communicable Diseases Intelligence

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Contents:

VIRUS REPORTING SCHEME - A total of 1667 reports was processed this period. While Influenza A activity continues to decline (see Table 1) there has been increasing Influenza B activity over the last four periods. This activity is in contrast to the low level of Influenza B activity for the same period in 1984 (see Table 2).

TABLE 1

	1984	1985
Influenza A reports, generation 14, 20 June-3 July	-	41
Influenza A reports, generation 15, 4 July-17 July	6	121
Influenza A reports, generation 16, 18 July-31 July	-	246
Influenza A reports, generation 17, 1 Aug-14 Aug	31	151
Influenza A reports, generation 18, 15 Aug-28 Aug	47	100
Influenza A reports, generation 19, 29 Aug-11 Sep	31	59

TABLE 2

	1984	1985
Influenza B reports, generation 14, 20 June-3 July	-	9
Influenza B reports, generation 15, 4 July-17 July	4	7
Influenza B reports, generation 16, 18 July-31 July	4	16
Influenza B reports, generation 17, 1 Aug-14 Aug	6	39
Influenza B reports, generation 18, 15 Aug-28 Aug	3	53
Influenza B reports, generation 19, 29 Aug-11 Sep	3	105

A case of Q Fever was reported in a meat worker from South Australia, not involved in the Q Fever vaccine field trial being conducted in that State.

Erratum: CDI 85/18 p1.

AIDS Surveillance - Australia: There have been no reports of AIDS in the Australian Capital Territory.
The table should read

	Cases	Deaths
Australian Capital Territory	-	-
Northern Territory	1	-

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ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) - EUROPE.

As of 30 June 1985, 1226 cases of AIDS have been reported to the WHO Collaborating Centre on AIDS in Paris. This is an increase of 286 cases since 31 March 1985. To date a total of 626 deaths due to AIDS has been reported, a case fatality rate of 51%. In the participating 18 European countries an increase in the estimated rates of cases per million population has been observed. The first case of AIDS has been reported from Luxemburg (Table 1).

There is no change in the overall distribution of cases by risk group (Table 2). However the following geographic differences are noteworthy:

1) In northern Europe (Denmark, Finland, Netherlands, Norway, Sweden) most cases occur among male homosexuals.

2)In southern Europe (Italy, Spain) cases amongst intravenous drug abusers are particularly common.

3) In Belgium, most of the cases occur among patients from Central Africa.

TABLE 1: Total number of AIDS cases reported by 30 June 1985 in 18 European countries and estimated rates per million population

	July 1984	December 1984	March 1985	June 1985	Rates*
Austria	-	13	13	18	2.4
Belgium	-	65	81	99	10.0
Czechoslovakia	-	-	-	-	-
Denmark	28	34	41	48	9.4
Finland	-	5	5	6	1.2
France	180	260	307	392	7.0
Germany, Federal Republic of	79	135	162	220	3.6
Greece	2	6	7	9	0.9
Iceland	-	-	-	-	-
Italy	8	14	22	52	0.9
Luxemburg	-	-	-	1	2.5
Netherlands	21	42	52	66	4.6
Norway	-	5	8	11	2.6
Poland	-	-	-	-	-
Spain	14	18	29	38	1.0
Sweden	7	16	22	27	3.3
Switzerland	28	41	51	63	9.7
United Kingdom	54	108	140	176	3.1
Total	421	762	940	1226	

Deaths: 626 Case Fatality Rate: 51%

* Based on 1985 populations, INED, Paris.

TABLE 2: Distribution of AIDS cases by risk group and geographical origin in 18 European countries listed in Table 1, 30 June 1985

Risk group	Geographical origin				
	Europe	Caribbean	Africa	Others	Total
1. Male homosexuals or bisexuals	809	4	10	30	853
2. I.V. drug addicts	48	-	-	-	48
3. Haemophiliacs	38	-	-	1	39
4. Transfusion recipients (without other risk factors)	20	-	5	-	25
5. Homosexuals/bisexuals + I.V. drug addicts	15	-	1	2	18
6. No known risk factor					
- males	49	22	76	2	149
- females	25	9	36	-	70
7. Unknown	7	1	13	3	24
Total	1011	36	141	38	1226

EDUCATION AND FOSTER CARE OF CHILDREN INFECTED WITH LYMPHADENOPATHY-ASSOCIATED VIRUS/HUMAN T-LYMPHOTROPIC VIRUS TYPE III

(Based on MMWR (1985) 34:517-521)

The information and recommendations contained in this document were developed and compiled by the Centers for Disease Control (CDC) in consultation with individuals appointed by their organizations to represent the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officers, the National Association of County Health Officers, the Division of Maternal and Child Health (Health Resources and Services Administration), the National Association for Elementary School Principals, the National Association of State School Nurse Consultants, the National Congress of Parents and Teachers, and the Children's Aid Society. The consultants also included the mother of a child with acquired immune deficiency syndrome (AIDS), a legal advisor to a state education department, and several paediatricians who are experts in the field of paediatric AIDS. This document is made available to assist state and local health and education departments in developing guidelines for their particular situations and locations. These recommendations apply to all children known to be infected with LAV/HTLV-III. This includes children with AIDS as defined for reporting purposes (Table 1); children who are diagnosed by their physicians as having an illness due to infection with LAV/HTLV-III but who do not meet the case definition; and children who are asymptomatic but have virological or serological evidence of infection with LAV/HTLV-III. These recommendations do not apply to siblings of infected children unless they are also infected.

BACKGROUND

The Scope of the Problem: As of 20 August, 1985, 183 of the 12,599 reported cases of AIDS in the United States were among children under 18 years of age. This number is expected to double in the next year. Children with AIDS have been reported from 23 states, the District of Columbia, and Puerto Rico, with 75% residing in New York, California, Florida and New Jersey.

TABLE 1. Provisional case definition for acquired immune deficiency syndrome (AIDS) surveillance of children

For the limited purposes of epidemiological surveillance, CDC defines a case of paediatric acquired immune deficiency syndrome (AIDS) as a child who has had:

1. A reliably diagnosed disease at least moderately indicative of underlying cellular immune deficiency, and
2. No known cause of underlying cellular immune deficiency or any other reduced resistance reported to be associated with that disease.

The diseases accepted as sufficiently indicative of underlying cellular immune deficiency are the same as those used in defining AIDS in adults. In the absence of these opportunistic diseases, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis will be considered indicative of AIDS unless test(s) for LAV/HTLV-III are negative. Congenital infections, e.g., toxoplasmosis or herpes simplex virus infection in the first month after birth or cytomegalovirus infection in the first 6 months after birth must be excluded.

Specific conditions that must be excluded in a child are:

1. Primary immune deficiency diseases - severe combined immune deficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinemia, or hypogammaglobulinemia with raised IgM.
2. Secondary immune deficiency associated with immunosuppressive therapy, lymphoreticular malignancy or starvation.

The 183 AIDS patients reported to CDC represent only the most severe form of LAV/HTLV-III infection i.e. those children who develop opportunistic infections or malignancies (Table 1). As in adults with LAV/HTLV-III infection, many infected children may have milder illness or may be asymptomatic.

Legal Issues: Among the legal issues to be considered in forming guidelines for the education and foster care of LAV/HTLV-III infected children are the civil rights aspects of public school attendance, the protections for handicapped children under 20 USC 1401 et seq. and 29 USC 794, the confidentiality of a student's school record under state laws and under 20 USC 1232g, and employee right-to-know statutes for public employees in some states.

Confidentiality Issues: The diagnosis of AIDS or associated illnesses evokes much fear from others in contact with the patient and may evoke suspicion of life styles that may not be acceptable to some persons. Parents of LAV/HTLV-III infected children should be aware of the potential for social isolation should the child's condition become known to others in the care or educational setting. School, day-care and social service personnel and others involved in educating and caring for these children should be sensitive to the need for confidentiality and the right to privacy in these cases.

ASSESSMENT OF RISKS

Risk Factors for Acquiring LAV/HTLV-III Infection and Transmission. In adults and adolescents, LAV/HTLV-III is transmitted primarily through sexual contact (homosexual or heterosexual) and through parenteral exposure to infected blood or blood products. LAV/HTLV-III has been isolated from blood, semen, saliva and tears but transmission has not been documented from saliva and tears. Adults at increased risk for acquiring LAV/HTLV-III include homosexual/bisexual men, intravenous drug abusers, persons transfused with contaminated blood or blood products, and sexual contacts of persons with LAV/HTLV-III infection or in groups at increased risk for infection.

The majority of infected children acquire the virus from their infected mothers in the perinatal period[1-4]. In utero or intrapartum transmission are likely, and one child reported from Australia apparently acquired the virus postnatally, possibly from ingestion of breast milk.[5] Children may also become infected through transfusion of blood or blood products that contain the virus. 70% of the paediatric cases reported to CDC occurred among children whose parent had AIDS or was a member of a group at increased risk of acquiring LAV/HTLV-III infection; 20% of the cases occurred among children who had received blood or blood products; and for 10%, investigations are incomplete.

Risk of Transmission in the School, Day-Care or Foster-Care Setting. None of the identified cases of LAV/HTLV-III infection in the United States are known to have been transmitted in the school, day-care, or foster-care setting or through other casual person-to-person contact. Other than the sexual partners of LAV/HTLV-III infected patients and infants born to infected mothers, none of the family members of the over 12,000 AIDS patients reported to CDC have been reported to have AIDS. Six studies of family members of patients with LAV/HTLV-III infection have failed to demonstrate LAV/HTLV-III transmission to adults who were not sexual contacts of the infected patients or to older children who were not likely at risk from perinatal transmission[6-9].

Based on current evidence, casual person-to-person contact as would occur among schoolchildren appears to pose no risk. However, studies of the risk of transmission through contact between younger children and neurologically handicapped children who lack control of their body secretions are very limited. Based on experience with other communicable diseases, a theoretical potential for transmission would be greatest among these children. It should be emphasized that any theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes to blood and possibly other body fluids of an infected person.

Risks to the Child with LAV/HTLV-III Infection. LAV/HTLV-III infection may result in immune deficiency. Such children may have a greater risk of encountering infectious agents in a school or day-care setting than at home. Foster homes with multiple children may also increase the risk. In addition, younger children and neurologically handicapped children who may display behaviours such as mouthing of toys would be expected to be a greater risk for acquiring infections. Immunodepressed children are also at greater risk of suffering severe complications from such infections as chickenpox, cytomegalovirus, tuberculosis, herpes simplex and measles. Assessment of the risk to the immunodepressed child is best

made by the child's physician who is aware of the child's immune status. The risk of acquiring some infections, such as chickenpox, may be reduced by prompt use of specific immune globulin following a known exposure.

RECOMMENDATIONS

1. Decisions regarding the type of educational and care setting for LAV/HTLV-III infected children should be based on the behaviour, neurological development and physical condition of the child and the expected type of interaction with others in that setting. These decisions are best made using the team approach including the child's physician, public health personnel, the child's parent or guardian and personnel associated with the proposed care or educational setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighed.
2. For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of LAV/HTLV-III. These children should be allowed to attend school and after-school day-care and to be placed in a foster home in an unrestricted setting.
3. For the infected preschool-aged child and for some neurologically handicapped children who lack control of their body secretions or who display behaviour such as biting and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings. Children infected with LAV/HTLV-III should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.
4. Care involving exposure to the infected child's body fluids and excrement, such as feeding and diaper changing, should be performed by persons who are aware of the child's LAV/HTLV-III infection and the modes of possible transmission. In any setting involving an LAV/HTLV-III infected person, good handwashing after exposure to blood and body fluids and before caring for another child should be observed and gloves should be worn if open lesions are present on the caretaker's hands. Any open lesions on the infected person should also be covered.
5. Because other infections in addition to LAV/HTLV-III can be present in blood or body fluids all schools and day-care facilities, regardless of whether children with LAV/HTLV-III infection are attending, should adopt routine procedures for handling blood or body fluids. Soiled surfaces should be promptly cleaned with disinfectants, such as household bleach (diluted 1 part bleach to 10 parts water). Disposable towels or tissues should be used whenever possible and mops should be rinsed in the disinfectant. Those who are cleaning should avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.
6. The hygienic practices of children with LAV/HTLV-III infection may improve as the child matures. Alternatively, the hygienic practices may deteriorate if the child's condition worsens. Evaluation to assess the need for a restricted environment should be performed regularly.
7. Physicians caring for children born to mothers with AIDS or at increased risk of acquiring LAV/HTLV-III infection should consider testing the children for evidence of LAV/HTLV-III infection for medical reasons. For example,

vaccination of infected children with live virus vaccines, such as the measles-mumps-rubella vaccine (MMR), may be hazardous. These children also need to be followed closely for problems with growth and development and given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella. In the event that an antiviral agent or other therapy for LAV/HTLV-III infection becomes available, these children should be considered for such therapy. Knowledge that a child is infected will allow parents and other caretakers to take precautions when exposed to the blood and body fluids of the child.

8. Adoption and foster-care agencies should consider adding LAV/HTLV-III screening to their routine medical evaluations of children at increased risk of infection before placement in the foster or adoptive home, since these parents must make decisions regarding the medical care of the child and must consider the possible social and psychological effects on their families.
9. Mandatory screening as a condition for school entry is not warranted based on available data.
10. Persons involved in the care and education of LAV/HTLV-III infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).
11. All educational and public health departments, regardless of whether LAV/HTLV-III infected children are involved, are strongly encouraged to inform parents, children and educators regarding LAV/HTLV-III and its transmission. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others.

References

1. N Engl J Med 1984; 310:76-81
2. JAMA 1984; 252:639-44
3. JAMA 1983; 249:2350-6
4. JAMA 1983; 249:2345-9
5. Lancet 1985; i:896-8
6. CDC. Unpublished data
7. Pediatric Infectious Disease (in press)
8. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, Georgia, April 1985.
9. EIS Conference, Atlanta, Georgia, April 1985.

T-LYMPHOTROPIC RETROVIRUSES OF NON-HUMAN PRIMATES - WHO INFORMAL MEETING

(Based on WER(1985)60:269-70)

An informal group of experts met in Geneva on 15 and 16 July 1985 to discuss recent findings concerning T-lymphotropic retroviruses of non-human primates and to advise WHO concerning the significance of these agents and the need for international collaborative research in this field.

Several species of monkeys and apes, in the wild and in captivity, harbour retroviruses. Three exogenous retroviruses have been isolated recently from Old World primates: simian T-lymphotropic viruses (STLV) types I and III and Mason-Pfizer monkey virus (MPMV)-related agents. Included in the species

which may be infected with such viruses are African green and Rhesus monkeys the tissues of which are used for the preparation of reagents and vaccines.

STLV I, STLV III and MPMV-related viruses have been isolated from monkeys suffering from immune deficiency diseases in several primate centres in the United States of America. STLV III is clearly distinguishable from human T-lymphotropic retroviruses but shares structural and antigenic properties. STLV III has recently been isolated from apparently healthy African green monkeys imported from Africa to the United States. Serological studies of African green monkeys held in captivity in the United States and Europe or caught in the wild in Africa indicate that a proportion of these animals may be infected by STLV III. It is not known how long such viruses have been present in African green and Rhesus monkeys but serological evidence suggests that African green monkeys in Africa may have harboured agents similar to STLV III for more than 20 years.

The implications of the findings of simian T-lymphotropic retroviruses in regard to the preparation of monkey kidney cell cultures were considred as follows:

(a) By analogy to their human counterparts, it is probable that the replication of simian T-lymphotropic viruses in vitro is restricted to lymphocytes. Monkey kidney cell culture would be expected to contain few, if any, T-lymphocytes.

(b) During the 1970s representative bulk and final preparations of live polio vaccines prepared in African green monkey kidney cultures were tested for the presence of retroviruses by reverse transcriptase assays. In addition, primary monkey kidney cell cultures, including those from African green monkeys, were examined after chemical induction by electron microscopy for virus-like particles and for particle-associated reverse transcriptase activity. No evidence was found for the presence of retroviruses.

(c) Current tests of WHO poliovirus types 1, 2 and 3 vaccine seed stocks as well as more than 20 vaccine lots in Europe and North America have failed to yield evidence of retroviruses. In addition, 250 vaccine recipients in Europe and North America were tested for LAV/HTLV-III antibodies and were found to be negative. Thirty of these were negative for antibodies to STLV-III.

(d) Long term and continuing follow-up of recipients of live polio vaccine suggest the absence of adverse effects potentially associated with retrovirus.

The WHO Group concluded that studies of the molecular structure and biology of lymphotropic retroviruses from non-human primates offer unique models relevant to the study of the human counterpart viruses. They recommended appropriate plans to make effective use of existing knowledge and outlined a coordinated research programme.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD - 29/8/85 to 11/9/85 BULLETIN NUMBER 85/19
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				2		29	1	35
0101	ADENOVIRUS TYPE 1				6	1				7
0102	ADENOVIRUS TYPE 2				1	6	3		5	15
0103	ADENOVIRUS TYPE 3	1			1		1			3
0104	ADENOVIRUS TYPE 4								1	1
0105	ADENOVIRUS TYPE 5				1		3			4
0106	ADENOVIRUS TYPE 6								1	1
0107	ADENOVIRUS TYPE 7	3					1		1	5
0114	ADENOVIRUS TYPE 14								1	1
0137	ADENOVIRUS TYPE 37								1	1
0199	ADENOVIRUS TYPING PENDING		3	2		13				18
0201	INFLUENZA A VIRUS	12	1	14	12		3	2	9	53
0202	INFLUENZA A VIRUS SUBTYPE H3N2				2	1	2	1		6
0203	INFLUENZA B VIRUS	3		1	20	42	15	6	18	105
0301	PARAINFLUENZA VIRUS TYPE 1				1	2	1	1	2	7
0302	PARAINFLUENZA VIRUS TYPE 2		1		1					2
0303	PARAINFLUENZA VIRUS TYPE 3	1	3			4	2	13	3	26
0400	RESPIRATORY SYNCYTIAL VIRUS (RS)	6	2	4	19	13	39	53	22	158
0500	RHINOVIRUS (ALL TYPES)		1	2	2	3	5	12	1	26
0600	MYCOPLASMA PNEUMONIAE	2		4	1			2	2	11
0700	ORNITHOSIS-PSITTACOSIS				1					1
0809	COXSACKIEVIRUS A9				1					1
0816	COXSACKIEVIRUS A16				2				1	3
0904	COXSACKIEVIRUS B4					4	1			5
0905	COXSACKIEVIRUS B5						1			1
1003	ECHOVIRUS TYPE 3					1				1
1006	ECHOVIRUS TYPE 6						1			1
1007	ECHOVIRUS TYPE 7		1		1	4	1		1	8
1009	ECHOVIRUS TYPE 9								1	1
1021	ECHOVIRUS TYPE 21				1					1
1031	ECHOVIRUS TYPE 31								1	1
1100	POLIOVIRUS NOT TYPED					1				1
1102	POLIOVIRUS TYPE 2								3	3
1103	POLIOVIRUS TYPE 3						2		2	4
1104	POLIOVIRUS-VACCINAL STRAIN						2	4		6
1200	MUMPS VIRUS	2	2						1	5
1300	HERPES VIRUS GROUP-NOT TYPED	28		2	2		2	8		42
1301	HERPES SIMPLEX VIRUS NOT-TYPED		4		5					9
1302	EPSTEIN-BARR VIRUS (EB VIRUS)	1		3	1		1		6	12
1303	VARICELLA-ZOSTER VIRUS	2	3		3			2	3	13
1306	HERPES SIMPLEX TYPE 1	12		11	40	2	14	74	18	171
1307	HERPES SIMPLEX TYPE 2	77		22	62		7	154	53	375
1399	HERPES VIRUS TYPING PENDING		2			1	36	1		40
1401	COXIELLA BURNETI	2		2			1			5
1402	OTHER RICKETTSIAE			1						1
1502	PICORNA VIRUS-NOT TYPED	2		1				8	2	13
1521	MEASLES VIRUS	2								2
1522	RUBELLA VIRUS	2				1			7	10
1530	HEPATITIS A VIRUS	1					7			8
1531	HEPATITIS B VIRUS				9		24			33
1532	HEPATITIS B ANTIGEN	47		8			2	20	19	96
1535	HEPATITIS A ANTIBODY	6		1	6			4	4	21
1541	CHLAMYDIA A - C TRACHOMATIS	21		1			30	26	34	112
1556	CMV - CYTOMEGALOVIRUS	6	3	3	5	6	7	15	13	58
1562	REOVIRUS (ALL TYPES)							3		3
1563	CORONAVIRUS								1	1
1564	ROTAVIRUS	18	13	14	14	21	7	1		88
1599	ENTEROVIRUS TYPING PENDING		1	3		2				6
9992	ROSS RIVER VIRUS							12		12
9994	SMALL VIRUS (LIKE) PARTICLE	2	2							4
9995	DENGUE							3		3
9998	ARBO. GROUP B.							1		1
Total		262	42	99	220	130	221	455	238	1,667

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 29/8/85 to 11/9/85 ....
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.....		22					9				
0101 ADENOVIRUS TYPE 1.....		6				1					
0102 ADENOVIRUS TYPE 2.....		9					3				
0103 ADENOVIRUS TYPE 3.....							2				
0105 ADENOVIRUS TYPE 5.....		3					1				
0106 ADENOVIRUS TYPE 6.....		1									
0107 ADENOVIRUS TYPE 7.....		4									
0201 INFLUENZA A VIRUS.....	6	36	1				1	1		1	2
0202 INFLUENZA A VIRUS SUBTYPE H3N2		5									
0203 INFLUENZA B VIRUS.....	3	85				2	1		3		
0301 PARAINFLUENZA VIRUS TYPE 1....		6									
0302 PARAINFLUENZA VIRUS TYPE 2....		2									
0303 PARAINFLUENZA VIRUS TYPE 3....		25				1					
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....	3	153									
0500 RHINOVIRUS (ALL TYPES).....		26		1							
0600 MYCOPLASMA PNEUMONIAE.....	1	3							1		
0700 ORNITHOSIS-PSITTACOSIS.....		1									
0809 COXSACKIEVIRUS A9.....											1
0816 COXSACKIEVIRUS A16.....											3
0904 COXSACKIEVIRUS B4.....		3					1				
0905 COXSACKIEVIRUS B5.....							1				
1006 ECHOVIRUS TYPE 6.....		1									
1007 ECHOVIRUS TYPE 7.....		4		2		1	1				
1009 ECHOVIRUS TYPE 9.....											1
1021 ECHOVIRUS TYPE 21.....				1							
1031 ECHOVIRUS TYPE 31.....							1				
1102 POLIOVIRUS TYPE 2.....		2					1				
1103 POLIOVIRUS TYPE 3.....		1					3				
1104 POLIOVIRUS-VACCINAL STRAIN....	2	4									
1200 MUMPS VIRUS.....	1	1	3								
1300 HERPES VIRUS GROUP-NOT TYPED..	3					1					21
1301 HERPES SIMPLEX VIRUS NOT-TYPED		1									3
1302 EPSTEIN-BARR VIRUS (EB VIRUS).	2	1						2			
1303 VARICELLA-ZOSTER VIRUS.....	1	1							1		10
1306 HERPES SIMPLEX TYPE 1.....	5	11		1		1	1				93
1307 HERPES SIMPLEX TYPE 2.....	8										115
1402 OTHER RICKETTSIAE.....		1									
1502 PICORNA VIRUS-NOT TYPED.....	1	2	1				7				2
1521 MEASLES VIRUS.....											2
1522 RUBELLA VIRUS.....	2										4
1530 HEPATITIS A VIRUS.....								7			
1531 HEPATITIS B VIRUS.....	2							13			
1532 HEPATITIS B ANTIGEN.....	42						1	42			
1535 HEPATITIS A ANTIBODY.....	4						1	17			
1541 CHLAMYDIA A - C.TRACHOMATIS...								3			
1556 CMV - CYTOMEGALOVIRUS.....	1	29				1		2		1	1
1562 REOVIRUS (ALL TYPES).....		3									
1563 CORONAVIRUS.....		1									
1564 ROTAVIRUS.....	1	1					88				
9992 ROSS RIVER VIRUS.....	2										1
9994 SMALL VIRUS (LIKE) PARTICLE...	1						3				
9995 DENGUE.....											1
Total.....	91	454	5	5		8	126	87	5	2	260

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 29/8/85 to 11/9/85 ...
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									1
0101 ADENOVIRUS TYPE 1.....								2		
0102 ADENOVIRUS TYPE 2.....			1				2			
0103 ADENOVIRUS TYPE 3.....								1		
0104 ADENOVIRUS TYPE 4.....								1		
0107 ADENOVIRUS TYPE 7.....									1	
0114 ADENOVIRUS TYPE 14.....										1
0137 ADENOVIRUS TYPE 37.....	1									
0201 INFLUENZA A VIRUS.....							4	1	1	
0202 INFLUENZA A VIRUS SUBTYPE H3N2								2		
0203 INFLUENZA B VIRUS.....					1		1	12		
0301 PARAINFLUENZA VIRUS TYPE 1....								1		
0302 PARAINFLUENZA VIRUS TYPE 2....								1		
0303 PARAINFLUENZA VIRUS TYPE 3....								1	1	
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....							1	1	1	
0500 RHINOVIRUS (ALL TYPES).....							1			
0600 MYCOPLASMA PNEUMONIAE.....					2		1	2		
0809 COXSACKIEVIRUS A9.....								1		
0904 COXSACKIEVIRUS B4.....							1			
1003 ECHOVIRUS TYPE 3.....									1	
1007 ECHOVIRUS TYPE 7.....								1		
1100 POLIOVIRUS NOT TYPED.....										1
1300 HERPES VIRUS GROUP-NOT TYPED..	1	16			1					
1301 HERPES SIMPLEX VIRUS NOT-TYPED		1								
1302 EPSTEIN-BARR VIRUS (EB VIRUS).			3					2	1	
1303 VARICELLA-ZOSTER VIRUS.....									1	
1306 HERPES SIMPLEX TYPE 1.....	10	49			2			2		
1307 HERPES SIMPLEX TYPE 2.....	1	255								
1401 COXIELLA BURNETI.....			1				3	1	1	
1502 PICORNA VIRUS-NOT TYPED.....					1					
1522 RUBELLA VIRUS.....			1		3			1	1	
1530 HEPATITIS A VIRUS.....									1	
1531 HEPATITIS B VIRUS.....									18	
1532 HEPATITIS B ANTIGEN.....									12	
1535 HEPATITIS A ANTIBODY.....								1		
1541 CHLAMYDIA A - C.TRACHOMATIS...	2	106							1	
1556 CMV - CYTOMEGALOVIRUS.....		5	3			6	2	2	6	3
9992 ROSS RIVER VIRUS.....					8			4		
9995 DENGUE.....					3			2		
9998 ARBO. GROUP B.					1					
Total.....	16	432	9		22	6	16	42	47	6