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Communicable Diseases Intelligence

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VIRUS REPORTING SCHEME - Since the CDI was not published over the Christmas - New Year, this issue contains a compilation of the virus reports for the two periods i.e. 9-22 December 1982 and 23 December 1982 - 5 January 1983. A total of 1983 reports were received for the two periods. Parainfluenza virus type 3 continued to predominate respiratory infections in children (75 reports for the two periods compared with 51, 31 and 33 for the previous three periods). At the Royal Children's Hospital, Melbourne, the virus was isolated from nasal aspirates from a two year old girl with encephalitis, and a three month old sudden infant death syndrome victim. Increases in the number of echovirus type 11 infections were reported by the State Health Laboratory, Brisbane, and Fairfield Hospital, Melbourne.

- A further 42 reports of rubella infection were reported by Fairfield Hospital among young naval personnel at HMAS Cerberus (see CDI 82/25). The laboratory also detected specific IgM against rubella in a female who presented with a rash 40 weeks into pregnancy. The baby was delivered two weeks later with no evidence of infection. Specific IgM against rubella was also detected by the State Health Laboratory Services, Perth, in a ten year old boy with encephalitis.

- Two laboratories reported virus isolations from semen that had been cryopreserved for human artificial insemination by donor. Coxsackievirus B3 was isolated by Fairfield Hospital from semen donated by a patient with orchitis and an upper respiratory tract infection; and mumps virus was isolated from three semen specimens by the State Health Laboratory Services, Perth,. One of these donors had presented with parotitis.

- Enterovirus type 71 was isolated from skin lesions by Fairfield Hospital from a 28 year old male with hand-foot-and-mouth disease (HFMD). Coxsackievirus A16 is commonly associated with this syndrome, although coxsackieviruses A5 and A10 have been responsible for sporadic cases. In Australia, USA and Sweden, enterovirus type 71 has been associated predominantly with central nervous system disease, but in Japan in 1978, the virus caused a state-wide epidemic of HFMD with more than 36,000 cases reported (Jap. J. Med. Sci. and Biol. (1981) 34(3): 191).

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PENICILLINASE-PRODUCING N.GONORRHOEAE (PPNG) CONJUNCTIVITIS

(Contributed by T.G. Kerr and J.H. Andrew, Department of Microbiology, St. Vincent's Hospital, Melbourne).

While in Manila during April 1981, an Australian male developed urethritis five days after sexual contact. He was treated there with intramuscular penicillin and prescribed tablets (presumed to be penicillin) for six days. The urethral discharge cleared after three days, and he had further sexual contacts. Two weeks later the urethral discharge recurred, and he took five "penicillin" tablets. The duration of this second episode of urethritis is unknown. Approximately one week later, at the end of his stay in the Philippines, he developed sore eyes. The patient did not seek further treatment until his return to Australia three days later.

The patient presented initially to the Royal Victorian Eye and Ear Hospital with purulent conjunctivitis, and where a presumptive diagnosis of gonococcal infection was made following the detection of intracellular Gram-negative diplococci in conjunctival exudate. Further investigations and management were undertaken at St. Vincent's Hospital. Since the clinical history suggested a PPNG infection, spectinomycin 2 gm IM was given, and the patient instructed to wash his eyes with saline and to apply ophthalmic neosporin ointment. PPNG was cultured from eye, throat, and urethral, but not rectal, swabs taken at first presentation. Syphilis serology was non-reactive. MIC values for the isolates were assayed by the Microbiological Diagnostic Unit, Melbourne University, and were penicillin > 2.0 µg/ml, tetracycline 2.0 µg/ml and spectinomycin 8.0 µg/ml. Swabs taken one week later were negative for all previously cultured sites, and the patient was symptom-free at recall on the second week.

Gonococcal conjunctivitis in adults is uncommon. During 1979, 21 cases of a total of 61 125 new cases of gonorrhoea were reported in the UK[1]. Transmission may result from cross-infection, as concluded in a recent outbreak among Australian Aborigines[2] and in two of three cases reported in American servicemen[3]; or more commonly, and apparently in this case, from contamination of a patient's eyes with genital secretions derived either from the patient or a sexual partner. Although pharyngeal gonorrhoea is a well recognized complication of oral-genital sexual practices[4,5], the passage of gonococci down the naso-lacrimal ducts to the pharynx may be an alternative explanation for the positive pharyngeal culture observed.

The choice of treatment for PPNG conjunctivitis will depend on the clinical circumstances. Ophthalmia neonatorum due to PPNG has been treated successfully with a number of combined topical and systemic antibiotics[6,7,8]. In adults, treatment needs to be modified to cover other genital and extra-genital sites of infection. Antibiotics known to be active against PPNG *in vitro* include spectinomycin, cefoxitin, sulphamethoxazole with trimethoprim, kanamycin and gentamicin. Pharyngeal gonorrhoea is often difficult to eradicate[5,9], so physicians should always ensure a clinical and bacteriological cure.

The case described illustrates the difficulty of obtaining adequate treatment in some countries, and the need to suspect

PPNG infection in imported cases of gonorrhoea. Ocular gonococcal infections may occur as prolonged asymptomatic infections[10,11], as well as severe, rapidly progressive and invasive infections. This severity was illustrated in December 1981, when a young male presented to St. Vincent's Hospital with gonococcal ophthalmitis caused by a penicillin-sensitive strain, and in whom one of the bilateral ulcers progressed to perforation despite appropriate therapy.

References

1. CDR (1980) 80/46 : 3
2. CDI (1981) 81/13 : 3
3. MMWR (1981) 30 : 341
4. In : Handbook on Sexually Transmitted Diseases, National Health and Medical Research Council (1978) : 6
5. CDI (1982) 82/25 : 3
6. BMJ (1979) 1 : 380
7. BMJ (1980) 2 : 483
8. J. Paed. (1982) 100 : 925
9. WHO Technical Report Series No. 616 (1978)
10. Can. J. Ophthalmol (1973) 8 : 421
11. JAMA (1981) 246 : 242

GONOCOCCAL SURVEILLANCE - SPECTINOMYCIN DISC DIFFUSION TEST

In CDI 82/23 : page 1, it was stated that spectinomycin discs (100 µg) for susceptibility testing of N.gonorrhoeae isolates were not generally available, and a laboratory-based technique was therefore suggested. The Editor has since been informed that such discs are commercially available, free of charge, from UpJohn Pty Ltd., P.O. Box 138, Parramatta, New South Wales 2150. Inquiries about the discs should be directed to the Technical Services Manager, telephone number 02-6380531.

FASCIOLIASIS SURVEILLANCE

Fascioliasis is uncommon in humans, although it is endemic in sheep and cattle. The life cycle of the sheep liver fluke (Fasciola hepatica) is complex and dependent on the weather[1]. The adult fluke is hermaphrodite and lives in the bile ducts of cattle and sheep. Each fluke can produce up to 50,000 eggs per day which pass on to pasture in the dung. In warm, moist soil, free-swimming miracidia hatch from the eggs and survive up to six hours during which time they must locate and penetrate a mud-dwelling snail. Lymnaea tomentosa is the common intermediate host in Australia, but colonies of Lymnaea columella, a common intermediate host in North America and New Zealand, have been found in non-farming districts of New South Wales and Western Australia[2]. Inside the snail the parasite reproduces asexually to produce several hundred cercariae which emerge, cast off their tails, and encyst on herbage where they can remain for several weeks until eaten by the final host. The immature flukes then cross the abdominal cavity to penetrate the liver and become sexually mature 12 weeks later. In the absence of treatment, flukes live for many years in the bile ducts of the final host.

None of the stages outside the final host can develop without adequate soil moisture - the soil must be saturated with a little free water on its surface for the free-swimming larvae - and temperatures above 10°C. Thus fascioliasis in animals

occurs predominantly in the winter rainfall and irrigation districts of Australia. Fascioliosis is also important in the New England and coastal districts of New South Wales where the rainfall is irregular, but often greatest is summer.

Human illness is usually reported in particularly bad fluke years, and in people who have eaten wild watercress or dandelions[3,4]. In managed watercress beds, the good flow of water renders the habitat unsuitable for snails of the genus Lymnaea, and as a further precaution commercial beds should be protected from contamination by animals and by surface water from surrounding fields. The fluke may survive in man for 9-13 years, passing viable ova in the faeces. The migration of the young fluke through the liver causes painful enlargement and pyrexia. The adult fluke causes liver pain and tenderness, possibly rigidity of the abdominal wall and diarrhoea. Less common features include bile duct obstruction and acute cholecystitis. Severe infections may be accompanied by weight loss, toxicity and anaemia. Rarely ectopic infections are reported affecting the brain, eyes, intestinal and abdominal walls and muscles of the neck. Leucocytosis and eosinophilia are usual. The prognosis is good in light infection; death is rare except in heavy infections with severe liver involvement.

A history of wild watercress or dandelion ingestion is crucial to the early diagnosis. Illness can be divided into invasive, latent and cholestatic phases[5], and ova may not be detected in the stools until the cholestatic phase develops. Early laboratory diagnosis depends on testing the serum for the presence of antibodies to Fasciola antigens[6]. Therapy is frequently disappointing. Drugs used with equivocal results include emetine hydrochloride, dehydroemetine hydrochloride, bithionol and chloroquine. Although metronidazole has been used, the antibiotic is ineffective against Fasciola infestation in sheep[4].

The risk of contracting liver fluke in Australia is small since it is now unusual for people to eat wild watercress. However, infection with one of the Oriental liver flukes, Clonorchis sinensis or Opisthorchis species, is occasionally recognized in immigrants from South East Asia[7]. These infections are acquired from eating raw freshwater fish and, though asymptomatic infection is common, obstructive jaundice may occur and cholangiocarcinoma may complicate chronic infections. In Montreal, Canada, 60 of 400 Chinese immigrants examined were infected with C.sinensis[8], so that there must be many unrecognized infections in our own Chinese communities.

References

1. CDR (1982) 82/45 : 3
2. In : "Synopsis of Zoonoses in Australia" (1980). Commonwealth Department of Health : 37
3. MJA (1975) 2 : 829
4. Aust. N.Z. J.Med. (1982) 12 : 525
5. MJA (1973) 1 : 295
6. J. Clin. Pathol. (1970) 23 : 636
7. CDI (1982) 82/8 : 1
8. J. Trop. Med. & Hyg. (1973) 76 : 291

HEPATITIS B VIRUS VACCINE SAFETY
(Based on MMWR (1982) 31 : 465)

An imported, inactivated hepatitis B virus (HBV) vaccine (produced by Merck, Sharp and Dohme) will shortly be available in Australia. Immunisation is achieved by a course of three injections at zero, one and six months, and has been shown to be effective and to achieve a good response in more than 90 per cent of healthy recipients. Guidelines for the use of the vaccine in Australia have yet to be formulated, although detailed immunisation practice recommendations have been published by the US Immunization Practices Advisory Committee(1).

The HBV vaccine is prepared from human plasma containing hepatitis B surface antigen (HBsAg). Hypothetical side effects from the vaccine include reactions to blood substances or to infectious agents present in donor plasma. Infectious agents that might be present are most likely to be viruses. Virus transmission by blood or blood products requires the virus to circulate in plasma or in cellular elements such as leucocytes. The chance of virus transmission increases with the duration of the viraemic state. HBV is the only well-characterised extra-cellular human virus with a prolonged carrier state. Other agents, presumably viruses, which remain unidentified despite their common association with post-transfusion hepatitis, are responsible for non-A/non-B hepatitis (NANBH). However, the epidemiology of the recently recognized group of clinical entities termed acquired immune deficiency syndrome (AIDS), manifested by Kaposi's sarcoma and opportunistic infections and associated with a specific defect in cell-mediated immunity(2), suggests an unidentified and uncharacterised blood-borne agent as a possible cause of the underlying immunological defect(3). Because AIDS occurs among populations that are sources of HBV-positive plasma, the Inter-Agency Group to Monitor Vaccine Development, Production and Usage, with representatives from the Centers for Disease Control, Food and Drug Administration and National Institutes of Health, has reviewed the available data on vaccine production and safety.

Vaccine plasma donors are screened, and only healthy individuals (HBsAg-positive) are selected. The plasmapheresis centres are licensed and inspected by the Food and Drug Administration. A physician gives each donor a complete physical examination, which includes a history and suitable laboratory tests. At the time of each donation, the donor's haemoglobin, haematocrit, and serum protein levels must be within normal limits. HBsAg-positive donor's levels of serum aminotransferase activity are permitted to exceed those limits set for otherwise healthy donors, but they must be stable.

The process for producing each lot of licensed HBV vaccine is designed to remove or inactivate infectious HBV and other viruses from the desired immunogen, the 22 nm HBsAg particle. The process relies on both biophysical elimination of infectious particles and treatments which inactivate viruses (pepsin at pH 2.0, 8M urea and formalin). The elimination of infectious virus by biophysical purification depends on the density and flotational property of HBsAg in contrast with those of infectious virus particles. The double ultracentrifugation process (isopyknic and rate zonal) has been proven effective in removing 10^4 infectious doses of HBV/ml,

as measured by chimpanzee inoculation. Pepsin treatment alone (1 µg/ml, pH 2.0, 37°C for 18 hours) inactivates 10^5 or more infectious doses of HBV/ml, as measured by chimpanzee inoculation; and has been shown to inactivate viruses in the rhabdovirus, poxvirus, togavirus, reovirus, herpesvirus and coronavirus groups. Urea treatment alone (8M, 37°C for four hours) inactivates 10^5 or more infectious doses of HBV/ml and has been shown to inactivate viruses in the rhabdovirus, myxovirus, poxvirus, togavirus, reovirus, picornavirus, herpesvirus and coronavirus groups. Slow viruses, characterised by the viruses of kuru and Creutzfeld-Jakob disease, are inactivated by 6M urea, a lesser concentration than that applied routinely to the HBV vaccine. Formalin alone inactivates HBV, as well as many other virus groups, including parvoviruses, retroviruses and the delta antigen.

Each lot of HBV vaccine is tested for sterility, innocuousness in animals, and pyrogenicity and is free of detectable viruses, as shown by inoculation into both human and monkey cell-culture systems. Additionally, 22 doses of each vaccine lot are inoculated intravenously into four chimpanzees.

HBV vaccine has been given to over 19,000 persons (6,000 of whom received vaccine between October 1975 and December 1981, and 13000 of whom received it in 1982). There is no known evidence of hepatitis as a result of HBV vaccination, and studies of aminotransferase levels in chimpanzees and humans confirm that HBV vaccine does not transmit the NANBH agent(s). To summarise, these findings indicate:

- Immediate side effects are minimal after receipt of HBV vaccine.
- No long-term reactions have been reported.
- The purification and inactivation process is known to inactivate representatives of all known groups of animal viruses.
- Each lot is safety tested in primates.
- No known cases of hepatitis B or NANBH have been transmitted by the vaccine, and no known occurrence of AIDS has been associated with the vaccine.

Some of the groups from which HBV vaccine is prepared or for which it is recommended are also at high risk for AIDS; therefore reports of AIDS among donors and vaccinees at some future time may be expected on the basis of chance alone.

References

1. MMWR (1982) 31 : 317
2. CDI (1982) 82/16 : 3
3. MMWR (1982) 31 : 644 and 652.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD - 9/12/82 - 5/1/83 BULLETIN NUMBER . 83/1

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	11	1		1	1	8	10	8	40
0101 ADENOVIRUS TYPE 1	1		1		2			4	8
0102 ADENOVIRUS TYPE 2			1	2		1		1	5
0103 ADENOVIRUS TYPE 3		1		1				2	4
0105 ADENOVIRUS TYPE 5				2	1	1			4
0107 ADENOVIRUS TYPE 7								1	1
0119 ADENOVIRUS TYPE 19				3				8	11
0199 ADENOVIRUS TYPING PENDING			6	1	16	9			32
0201 INFLUENZA A VIRUS	18		3	1		3	10	3	38
0202 INFLUENZA A VIRUS SUBTYPE H3N2	2	1					1		4
0203 INFLUENZA B VIRUS	10		5					1	16
0301 PARAINFLUENZA VIRUS TYPE 1						1			1
0302 PARAINFLUENZA VIRUS TYPE 2	1				1				2
0303 PARAINFLUENZA VIRUS TYPE 3	3	1	1	7	39	10	6	8	75
0399 PARAINFLUENZA VIRUS TYPING PENDING						2			2
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	2		1	2	2	2		5	14
0500 RHINOVIRUS (ALL TYPES)	4			2	24	6	5		41
0600 MYCOPLASMA PNEUMONIAE	79	2	4	2		8	21	23	139
0700 ORNITHOSIS-PSITTACOSIS	1								1
0809 COXSACKIEVIRUS A9	1			2					3
0902 COXSACKIEVIRUS B2								2	2
0903 COXSACKIEVIRUS B3	1	1		2			2		6
0904 COXSACKIEVIRUS B4								1	1
0905 COXSACKIEVIRUS B5		1					1	2	4
1000 ECHOVIRUS NOT TYPED							1	1	2
1002 ECHOVIRUS TYPE 2						1			1
1004 ECHOVIRUS TYPE 4				1					1
1006 ECHOVIRUS TYPE 6	1								1
1011 ECHOVIRUS TYPE 11		3	4	9		1	12	15	44
1014 ECHOVIRUS TYPE 14								1	1
1017 ECHOVIRUS TYPE 17				1					1
1021 ECHOVIRUS TYPE 21	1								1
1022 ECHOVIRUS TYPE 22		2	1	1				1	5
1024 ECHOVIRUS TYPE 24				2					2
1030 ECHOVIRUS TYPE 30	1								1
1099 ECHOVIRUS TYPING PENDING				6					6
1101 POLIOVIRUS TYPE 1								1	1
1102 POLIOVIRUS TYPE 2	1					1		1	3
1103 POLIOVIRUS TYPE 3						1			1
1104 POLIOVIRUS-VACCINAL STRAIN						2			2
1200 MUMPS VIRUS	17	4		2	3	4	4	5	39
1300 HERPES VIRUS GROUP-NOT TYPED	52			17		12			81
1301 HERPES SIMPLEX VIRUS NOT-TYPED		4		8				87	99
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	7	1						4	12
1303 VARICELLA-ZOSTER VIRUS	5	2		4		3			14
1306 HERPES SIMPLEX TYPE 1	19		7	45		35	35		141
1307 HERPES SIMPLEX TYPE 2	147		14	88		30	59		338
1399 HERPES VIRUS TYPING PENDING			15	3	9	4			31
1401 COXIELLA BURNETI	9		1	1			6		17
1502 PICORNA VIRUS-NOT TYPED	5		2					1	8
1514 MOLLUSCUM CONTAGIOSUM		1							1
1515 CONTAGIOUS PUSTULAR DERMATITIS (ORF VIRUS)	1								1
1521 MEASLES VIRUS	18			7	8	1	1		35
1522 RUBELLA VIRUS	28		1	60	3		9	6	107
1532 HEPATITIS B ANTIGEN	34		17	92		6	12	17	178
1535 HEPATITIS A ANTIBODY	2		1	20		10	6	21	60
1541 CHLAMYDIA A - C TRACHOMATIS	22		2			1		91	116
1556 CMV - CYTOMEGALOVIRUS	20	3	1	19	16	3	4	4	70
1563 CORONAVIRUS								1	1
1564 ROTAVIRUS	7	8	8	7	3	4			37
1571 ENTEROVIRUS TYPE 71 (BRCR)				1					1
1599 ENTEROVIRUS TYPING PENDING	6	6	24		18	1	6		61
ROSS RIVER VIRUS							1	2	3
ASTROVIRUS	1								1
SMALL VIRUS (LIKE) PARTICLE				4					4
Total	538	42	120	426	146	171	212	328	1,983

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 9/12/82 to 5/1/83 .... 83/1

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	Respir-atory	Enceph-alitis	Mening-itis	Para-lysis	CNS other unspec	GI	Hepa-tic	CVS	Urin-ary	Skin/ mucs memb
0101 ADENOVIRUS TYPE 1		3	1	1							
0102 ADENOVIRUS TYPE 2		2					2				
0103 ADENOVIRUS TYPE 3		1									
0105 ADENOVIRUS TYPE 5	1						1				1
0107 ADENOVIRUS TYPE 7		1									
0201 INFLUENZA A VIRUS	6	23	1						1		
0202 INFLUENZA A VIRUS SUBTYPE H3N2		4									
0203 INFLUENZA B VIRUS	2	4	1	1					1		
0302 PARAINFLUENZA VIRUS TYPE 2		2									
0303 PARAINFLUENZA VIRUS TYPE 3	4	65	1	1		1					1
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)		12									
0500 RHINOVIRUS (ALL TYPES)	1	39									1
0600 MYCOPLASMA PNEUMONIAE	40	88						1	1		3
0700 ORNITHOSIS-PSITTACOSIS	1										
0809 COXSACKIEVIRUS A9				3							
0902 COXSACKIEVIRUS B2									2		
0903 COXSACKIEVIRUS B3	1	3	1								
0904 COXSACKIEVIRUS B4									1		
0905 COXSACKIEVIRUS B5			1	2					1		
1000 ECHOVIRUS NOT TYPED		1									
1002 ECHOVIRUS TYPE 2							1				
1004 ECHOVIRUS TYPE 4				1							
1006 ECHOVIRUS TYPE 6				1							
1011 ECHOVIRUS TYPE 11	4	3	2	24		2	4		1		1
1014 ECHOVIRUS TYPE 14							1				
1017 ECHOVIRUS TYPE 17						1					
1021 ECHOVIRUS TYPE 21	1										
1022 ECHOVIRUS TYPE 22		2					1				1
1024 ECHOVIRUS TYPE 24				1							
1030 ECHOVIRUS TYPE 30	1										
1101 POLIOVIRUS TYPE 1				1							
1102 POLIOVIRUS TYPE 2							1				
1103 POLIOVIRUS TYPE 3							1				
1104 POLIOVIRUS-VACCINAL STRAIN	1										
1200 MUMPS VIRUS	9	2	5	8						1	3
1301 HERPES SIMPLEX VIRUS NOT-TYPED	3		2								5
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	2		1								
1303 VARICELLA-ZOSTER VIRUS	1					1					11
1306 HERPES SIMPLEX TYPE 1	6	3	1	1	1						65
1307 HERPES SIMPLEX TYPE 2	8										11
1401 COXIELLA BURNETI	6	2									
1502 PICORNA VIRUS-NOT TYPED	2										1
1514 MOLLUSCUM CONTAGIOSUM	1										
1515 CONTAGIOUS PUSTULAR DERMATITIS (ORF VIRUS)											1
1521 MEASLES VIRUS	4	4		3		3					22
1522 RUBELLA VIRUS	9	1	1								86
1532 HEPATITIS B ANTIGEN	57							114		1	
1535 HEPATITIS A ANTIBODY	7							47		1	
1556 CMV - CYTOMEGALOVIRUS	11	16	1		1			1		10	
1563 CORONAVIRUS		1									
1564 ROTAVIRUS							37				
1571 ENTEROVIRUS TYPE 71 (BRCR)											1
1599 ENTEROVIRUS TYPING PENDING							1		3		
9993 ASTROVIRUS							1				
9994 SMALL VIRUS (LIKE) PARTICLE							4				
Total	189	282	19	48	2	8	55	163	11	13	264

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

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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					1	1	1		
0102 ADENOVIRUS TYPE 2.....							1			
0103 ADENOVIRUS TYPE 3.....	3									
0105 ADENOVIRUS TYPE 5.....								1		
0119 ADENOVIRUS TYPE 19.....	7	4								
0201 INFLUENZA A VIRUS.....							4	11		
0202 INFLUENZA A VIRUS SUBTYPE H3N2								1		
0203 INFLUENZA B VIRUS.....				1			1	4	1	
0301 PARAINFLUENZA VIRUS TYPE 1....							1			
0303 PARAINFLUENZA VIRUS TYPE 3....							2	2		1
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....			1				1	1		
0500 RHINOVIRUS (ALL TYPES).....										1
0600 MYCOPLASMA PNEUMONIAE.....				1			3	21	2	
0903 COXSACKIEVIRUS B3.....		1						1		
1011 ECHOVIRUS TYPE 11.....								7		
1022 ECHOVIRUS TYPE 22.....						1				
1024 ECHOVIRUS TYPE 24.....								1		
1102 POLIOVIRUS TYPE 2.....			1					1		
1104 POLIOVIRUS-VACCINAL STRAIN....							1			
1200 MUMPS VIRUS.....		1	8	2				2	3	
1301 HERPES SIMPLEX VIRUS NOT-TYPED	1	45						1		
1302 EPSTEIN-BARR VIRUS (EB VIRUS).			6	1				1	2	
1303 VARICELLA-ZOSTER VIRUS.....			1							
1306 HERPES SIMPLEX TYPE 1.....	7	54	1					4		
1307 HERPES SIMPLEX TYPE 2.....	1	318								
1401 COXIELLA BURNETI.....					1		4	6		
1502 PICORNA VIRUS-NOT TYPED.....								1	1	1
1521 MEASLES VIRUS.....			1				2	3	1	
1522 RUBELLA VIRUS.....			2		5	1		9	6	
1532 HEPATITIS B ANTIGEN.....									6	
1535 HEPATITIS A ANTIBODY.....				1				2	3	
1541 CHLAMYDIA A - C.TRACHOMATIS...	1	115								
1556 CMV - CYTOMEGALOVIRUS.....		3	1		1	10	5	10	7	
1599 ENTEROVIRUS TYPING PENDING....				1						
9992 ROSS RIVER VIRUS.....					2			1		
Total.....	21	541	22	7	9	13	26	92	32	3

CDI 83/1

NOTIFIABLE DISEASES REPORTED IN AUSTRALIA

11th 4 Weekly Period for 1982

(10 October - 6 November 1982 incl.)

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Disease	N.S.W.	VIC	QLD	S.A.	W.A.	TAS.	N.T.	A.C.T.	Total	CUMULATIVE TOTAL TO DATE FOR YEAR
Amoebiasis	1		1						2	22
Ankylostomiasis			3	1					4	72
Anthrax									—	—
Arbovirus infection									—	57
Brucellosis	1								1	25
Campylobacter infections	9	N.N.	N.N.	61	N.N.	N.N.	9	N.N.	79	462
Chancroid				N.N.		N.N.	N.N.		—	7
Cholera									—	—
Congenital rubella syndrome		N.N.	N.N.		N.N.	N.N.	N.N.	N.N.	—	—
Diphtheria									—	1
Donovanosis		N.N.	4	N.N.	1	N.N.	8		13	107
Giardiasis	1	N.N.	N.N.	42	N.N.	N.N.	N.N.	N.N.	43	534
Genital herpes	79	N.N.	N.N.	28	N.N.	N.N.		N.N.	107	1136
Gonococcal ophthalmia neonatorum	1	N.N.			N.N.	N.N.	N.N.	N.N.	1	2
Gonorrhoea	214	280	61	57	115	8	63	8	806	10613
Hepatitis A (infectious)	13	35	30	8	5	2	3	3	99	1014
Hepatitis B (serum)	15	12	6	12	1		3	2	51	668
Hepatitis - unspecified	19	N.N.			5	N.N.	1		25	139
Hydatid disease	1			1					2	11
Lassa Fever			N.N.			N.N.	N.N.	N.N.	—	—
Legionnaires disease			N.N.		N.N.	N.N.	N.N.	N.N.	—	11
Leprosy								3	3	27
Leptospirosis	4	4		1	1				10	94
Lymphogranuloma venereum		N.N.	N.N.	N.N.	N.N.	N.N.			—	1
Malaria	10	7	22	2	3		2	2	48	433
Marburg Disease			N.N.			N.N.	N.N.	N.N.	—	—
Meningococcal infections	1		10		1	N.N.			12	66
Non-specific urethritis	392	N.N.	N.N.	79	N.N.	N.N.	N.N.	N.N.	471	5843
Ornithosis									—	8
Pertussis (whooping cough)	3	22	N.N.	2	N.N.	N.N.	N.N.	N.N.	27	196
Plague									—	—
Poliomyelitis									—	—
Q. fever	2		11	3	N.N.		N.N.		16	338
Rabies		N.N.	N.N.			N.N.	N.N.	N.N.	—	—

DISEASE	N.S.W.	VIC	QLD	S.A.	W.A.	TAS.	N.T.	A.C.T.	Total	CUMULATIVE TOTAL TO DATE FOR YEAR
Salmonella infections	7	6	60	13	5		38	5	134	1728
Shigella infections	4		3	3	8		30		48	375
Smallpox									—	—
Syphilis	158	24	30	1	9		43		265	2781
Tetanus			1						1	11
Trachoma		N.N.			N.N.	N.N.			—	—
Tuberculosis (all forms)	42	49	13	7	9			1	121	1169
Typhoid fever		1							1	20
Typhus (all forms)			1						1	4
Vibrio parahaemolyticus infections		N.N.	N.N.		N.N.	N.N.	N.N.	N.N.	—	—
Yellow Fever									—	—
Yersinia enterocolitica infections		N.N.	N.N.		N.N.	N.N.	N.N.	N.N.	—	2

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

N.N. Not Notifiable

ADJUSTMENTS

Amoebiasis	NSW	+	1
Campylobacter	NSW	+	33
Donovanosis	WA	+	4
Giardiasis	SA	-	1
"	NSW	+	18
Hepatitis A	Tas	+	10
Hepatitis B	SA	-	2
Malaria	SA	+	1
Pertussis	NSW	+	1
"	SA	+	17
Shigella	NSW	+	9
Tuberculosis	NT	+	2
Typhus	NSW	+	1
Yersinia	NSW	+	1