AUSTRALIA

Communicable Diseases Intelligence

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Contents:

VIRUS REPORTING SCHEME A total of 1108 reports were received this period. Patterns suggested by the reports included the continuation of the seasonal increase of respiratory syncytial virus infections (131 reports compared with 89, 79 and 47 for the previous three periods). Increases were also observed for M. pneumoniae infections (28 cases reported by the Institute of Clinical Pathology and Medical Research, Sydney, in patients whose ages ranged from 3-42 years), whereas parainfluenza virus and rhinovirus infections were fewer than previous periods.

- Arbovirus infections - The locations of the 18 cases of dengue fever reported by the State Health Laboratory, Brisbane, were Cairns (15) and Townsville (3). IgM antibodies against dengue virus types 1,2, 3 and 4 were detected in two patients from Cairns - a 40 year old female and her 11 year old son. The boy had severe acute haemolytic anaemia with intravascular haemolysis, haemoglobinuria, renal failure and myocarditis. The serum specimens from these two cases have been referred to the CDC Vector Borne Viral Diseases Division, Fort Collins, USA, to determine the infecting virus by means of monoclonal antibodies.

- Vaccinia virus was isolated by Fairfield Hospital, Melbourne, from a skin lesion on the lip of a 17 year old Navy serviceman who had been re-vaccinated against smallpox. The patient was toxic and feverish, and had presumably auto-inoculated himself. The continued vaccination of such personnel involves risk to both vaccinees and to susceptible contacts. Two countries (U.K. and Finland) have now discontinued smallpox vaccination of military personnel.

- Congenital infections - Rubella virus was isolated by Fairfield Hospital from nasal aspirate, urine, leucocytes, placenta and cord tissue of a six day old neonate with unilateral contract, retinopathy and patent ductus arteriosus. The mother had had rubella four weeks into her pregnancy. In addition, specific IgM against the virus was detected in two females who were 14 and 16 weeks pregnant respectively. The laboratory also isolated cytomegalovirus from a two month old girl with low birth weight, splenomegaly and chronic lung disease.

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Contributions are solicited, and do not preclude later publication elsewhere.

Figures given may be subject to revision.

GONOCOCCAL SURVEILLANCE - AUSTRALIA (JANUARY - MARCH 1982)

(Contributed by the Australian Gonococcal Surveillance Program (AGSP). Co-ordinator - J.W. Tapsall, Department of Microbiology, Prince of Wales Hospital, Sydney).

The AGSP collates the national prevailing penicillin sensitivities of N. gonorrhoeae isolates on a quarterly basis. Previous reports were published in CDI 81/25 and 82/5, and the standard method for the determination of minimal inhibitory concentration (MIC) values detailed in CDI 81/4.

A total of 1353 gonococcal isolates were tested for penicillin sensitivity during January-March 1982. The prevalences of three strain categories - "sensitive", "decreased sensitivity" and "penicillinase-producing N. gonorrhoeae (PPNG)" - are shown in Table 1.

TABLE 1 Penicillin sensitivity of N. gonorrhoeae isolates - January - March 1982

Percentages for October - December 1981 are in parentheses.

Source	Percentage of isolates		
	Sensitive(1)	Decreased sensitivity(2)	PPNG
Adelaide	35.8 (35.4)	55.7 (55.3)	0.1 (2.9)
Melbourne	31.9 (45.3)	43.6 (40.3)	3.2 (3.0)
Sydney	27.2 (25.4)	60.4 (53.0)	3.9 (7.0)
Perth	37.4 (45.3)	34.5 (20.7)	7.2 (11.5)
Brisbane	37.6 (37.4)	46.0 (55.2)	7.8 (4.9)
Australia	32.3 (38.0)	48.2 (44.9)	4.1 (4.9)

(1) MIC $\leq$ 0.008 µg/ml $\pm$ one doubling dilution
(2) MIC = 0.12 µg/ml $\pm$ one doubling dilution

As in the two previous quarters the penicillin sensitivities of the isolates had a bimodal distribution, with the two categories accounting for approximately 77% of the total. In this current quarter, strains classified as "resistant" to penicillin (MIC $\geq$ 1.0 µg/ml) comprised 1.3% of all isolates (data not available for earlier periods). Across the country percentages of "decreased sensitivity" strains increased since the previous quarter, particularly from Perth and to a lesser extent from Sydney and Melbourne. Sydney had the highest percentage of less sensitive organisms.

Fifty-five PPNG strains were isolated, representing 4.1% of all isolates. Brisbane was the only centre to show a substantial increase in the percentage of PPNG reports. Those from other centres decreased (Adelaide, Perth, Sydney) or remained constant (Melbourne).

Seasonal variation in the penicillin sensitivity of non-PPNG strains, particularly the decrease of sensitive strains during winter months, has been documented frequently(1). It has been suggested, but not proven, that the prescription of antibiotics for respiratory infections may eliminate these organisms. It is also tempting to speculate that the temporal variation in isolation rates of PPNG in Australia is the effect of their importation due to increased travel in the holiday season.

Reference

1. J. Inf. Dis. (1977) 136:684

SEXUALLY-TRANSMITTED INFECTION AS A RESULT OF SOCIAL-SEXUAL CONTACT USING CITIZEN'S BAND (CB) RADIO

(Based on CDR (1982) 82/17:4)

The state of communication today may be a factor in the transmission of sexually-transmitted disease (STD). In August 1981, a 21 year old male attended a STD clinic in Barnsley, UK, with non-specific urethritis (NSU). He reported five sexual contacts in the preceding month. Contact tracing was successful in three consorts and all were treated empirically. Two contacts were untraceable. Two secondary male contacts were traced and one was found to have NSU. A chlamydia culture service exists in the STD clinic only for female patients in whom the diagnosis of NSU is difficult. Of the three female primary contacts, only one was found to be positive for Chlamydia trachomatis, although the secondary contact with NSU was a contact of one of the chlamydia-negative females.

The index case had made four of his five sexual contacts by using his CB set. It seems that the making of new acquaintances using CB involves making oneself known using a call sign and then proceeding to the contact's location. Unfortunately, contact-tracing is difficult because contacts are often only known by their call-sign, and the suggestion of contact-tracing "on the air"[1] would involve an obvious breach of confidentiality. Fortunately, in the reported area the problem seemed confined to the "enthusiastic amateur", although it appears that in the cities, CB is sometimes used by their professional sisters to facilitate trade.

Reference

1. JAMA (1977) 237:23

HUMAN SALMONELLA INFECTIONS - SOUTH AUSTRALIA (1980-81)

(Contributed by A.S. Cameron, Communicable Disease Control Unit, S.A. Health Commission, Adelaide).

In 1981, 743 cases of salmonella infection were reported to the Communicable Disease Control Unit of the South Australian Health Commission compared with 727 cases in 1980. These infections comprising 44 serotypes represented all laboratory proven cases in the State which had an estimated population of 1,285,033 on 30 June 1981. No distinction has been drawn between acute and chronic disease, but all incidents recorded represented newly detected infections. The eight most common serotypes together with the age distributions are listed in Table 1. Their frequency percentage distributions by age are illustrated in Figure 1.

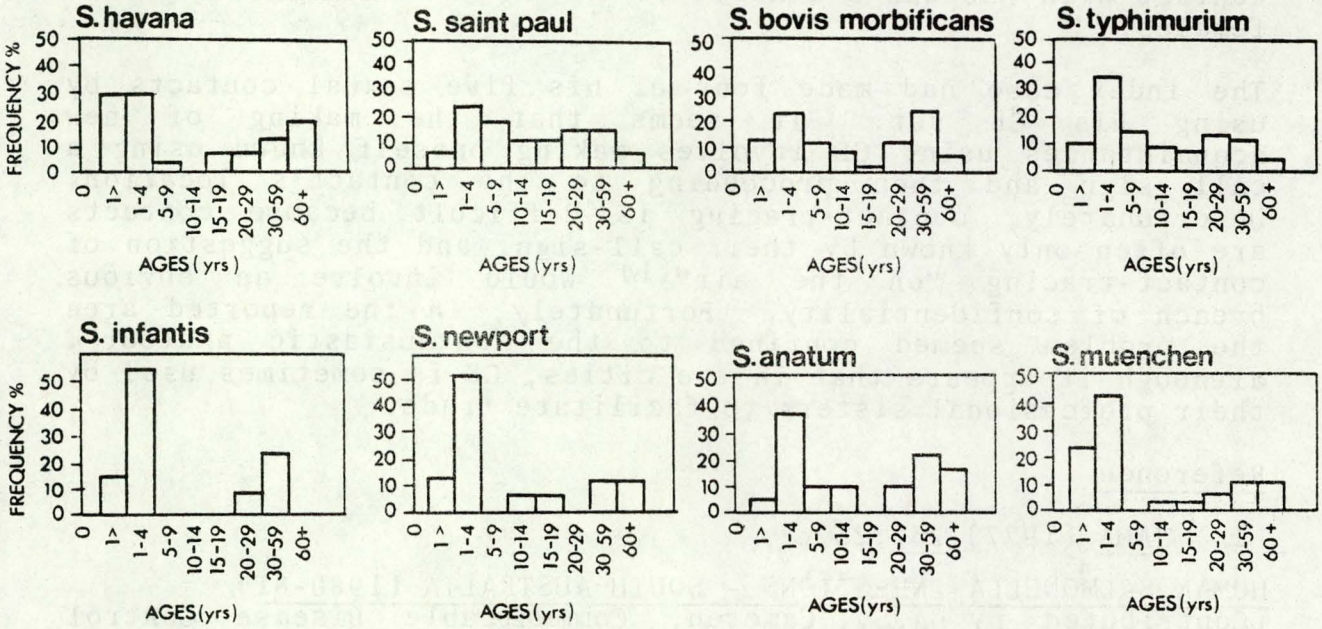
The age distribution of the cases was clearly bimodal, so no mean or median ages were calculated.

There were only two cases of S. typhi during the two years, both of which were imported. The large number of S. typhimurium isolates justified the importance of phage typing within the group. The phage typing system recently developed for S. bovis-morbificans also proved of epidemiological value (see CDI 82/1).

TABLE 1 The age distribution of the eight most frequently reported salmonella serotypes from human sources - South Australia 1980-81

Serotype	Number of isolates	Age (when stated)							
		<1	1-4	5-9	10-14	15-19	20-29	30-59	+60
S. typhimurium	847	76	265	111	60	53	103	89	28
S. bovis-morbificans	184	22	37	21	13	3	22	37	10
S. saint-paul	66	4	14	11	6	6	9	9	3
S. havana	37	9	9	1	0	2	2	4	6
S. muenchen	32	7	12	0	1	1	2	3	3
S. anatum	21	1	7	0	2	0	2	4	3
S. newport	17	2	8	0	1	1	0	2	2
S. infantis	16	2	7	0	0	0	1	3	0

FIGURE 1 Frequency percentage distribution by age of persons from whom salmonella were reported: South Australia 1980-81



PNEUMOCOCCAL VACCINATION TRIAL IN CHILDREN - SOUTH AUSTRALIA

(Contributed by R.M. Douglas and H. Miles, Department of Community Medicine, University of Adelaide; D. Hansman, J.C. Paton and M. Gregory, Department of Microbiology, Adelaide Children's Hospital)

A double-blind, randomized, controlled trial of pneumococcal vaccine is currently being conducted by a team from the Department of Community Medicine, Adelaide University, and the Department of Microbiology, Adelaide Children's Hospital. Interim results of studies on the vaccine's immunogenicity and effect on pneumococcal nasal carriage in 1273 children aged between 6-54 months are given below.

Polyvalent pneumococcal vaccine comprising the capsular polysaccharides of Streptococcus pneumoniae serotypes 1, 2, 3, 4, 6A, 7F, 8, 9N, 12F, 14, 18C, 19F, 23F and 25 has been used extensively in adults at high risk of disease in the USA since 1977, and it has recently been released for use in Australia (Pneumovax; Merck, Sharp and Dohme, through Commonwealth Serum Laboratories). The US Immunization Practices Advisory Committee recommendations on vaccine use were detailed in CDI 82/10 (see also corrigendum this bulletin). However,

because of uncertainty as to the adequacy of the immune response in young children, use of the vaccine has been generally restricted to patients over 2 years. Recent reports from Scandinavia and Papua New Guinea have suggested a benefit from vaccination in younger children, and the present trial endeavours to evaluate the potential usefulness of the vaccine as a routine childhood immunisation. The final outcome of the study, the impact of the vaccine on total respiratory and middle ear morbidity, will not be available for 12 months.

Serum was collected from 250 children prior to the vaccination, and antibodies to each of the 14 pneumococcal serotypes were measured by radioimmunoassay. Antibody was acquired naturally with increasing age for each serotype, but absolute levels of antibody varied significantly between serotypes. Levels were particularly low for types 6 and 18, but high for types 1 and 23. Children who were carrying pneumococci of types 14, 18, 19 or 23 at the time of serum collection had significantly higher antibody levels to the carried serotypes than age matched controls. This was not the case with pneumococcus type 6. All of these serotypes commonly cause disease in children.

Administration of the vaccine was associated with minimal reactivity. Mild soreness of the arm was recorded in 42% of children. Fever was observed in 19% of recipients at some stage during the first three days, although it was also reported by 13% of mothers of the placebo controls.

Nasal cultures yielded pneumococci from 30% of all children prior to vaccination. Of these isolates, 75% corresponded to vaccine serotypes, with types 6, 19, 23, 14, 9 and 18 respectively recovered most frequently. These serotypes are also the types which most commonly cause paediatric disease all over the world. Between 5-9 months after vaccination, 330 children were followed-up by monthly nose swabs. Of these, 80% of both vaccine and placebo recipients carried a pneumococcus at some stage during this period. This indicates that vaccination did not appear to reduce the overall frequency of S. pneumoniae carriage. However, vaccination was associated with a significant individual reduction in the carriage of the three important paediatric serotypes 14, 18 and 19.

Similarly, post-vaccination serum antibodies levels varied considerably with serotype. The poorest responses were against types 6, 14, 19 and 23, which are the four components that were hoped to be the most immunogenic. Poor reponses were also achieved against types 1 and 12, and intermediate responses against types 4 and 25. Types 2, 3, 7, 8 9 and 18 were excellent antigens, producing good rises and high post-immunisation antibody levels in all age groups from the age of six months. However, all vaccine antigens tended to be more immunogenic with increasing age. This age responsiveness was particularly striking for type 6; the percentage of individuals exhibiting a greater than two-fold increase in antibody titre rose progressively from nil in the 6-11 months age group to 78% by 48-54 months. On the other hand, 86% of children in the 6-11 month age group exhibited two-fold antibody rises against type 3. Despite this increased response with age, the overall antibody response to the vaccine (especially to the majority of the "paediatric" serotypes) was disappointing, even in the 48-54 month age group. The administration of a booster dose six months after primary vaccination did not enhance the antibody response in children under two years.

While the study remains incomplete, and the results of the morbidity impact are still not available, we conclude that the vaccine provided less than optimal antibody rises in children under four years of age. In addition, careful studies of the immunology, ecology and pathogenicity of pneumococcus type 6 are required. This serotype, which is frequently carried and commonly causes paediatric disease, was a poor immunogen when its polysaccharide was administered parenterally throughout the first three years of life. Its immunogenicity increased significantly after this period.

RESEARCH GROUP ON ACUTE RESPIRATORY INFECTIONS

Following recent initiatives from WHO, efforts are being made in numerous developing countries to develop better methods of control and management of acute respiratory infections, where in many they remain the leading cause of death. In Australia, acute respiratory infections are a primary cause of morbidity, a major cause of health services usage and the commonest communicable disease cause of death. It is clear that if the targets set by WHO for acute respiratory infections are to be met, new techniques must be evolved and the problem be more adequately specified in all countries than it is at present.

An informal Australian group has been formed to promote the exchange of information, and to provide a forum for the presentation of research into the prevention and management of acute respiratory infections. The Secretary of this new group is Dr R.M. Douglas, who is also the Chairman of the WHO Regional Advisory Panel on acute respiratory infections. A list of laboratories, institutions and research workers with a particular interest in acute respiratory infections is currently being prepared. He would appreciate answers to questions below from all interested in the problem.

1. Name and address of institution or research worker.

2. Principal interest or activity relating to acute respiratory infections.

3. Interest in contributing a presentation to a national meeting on acute respiratory infections - if so, please specify.

4. Interest in a regular newsletter relating to acute respiratory infections.

Please address your replies to:-

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ADELAIDE. S.A. 5001

CORRIGENDUM

In the article "Pneumococcal Polysaccharide Vaccine" published in CDI 82/10, the final paragraph on pages 6 and 1 detailing the limitations of the data used to derive the US Immunization Practices Advisory Committee recommendations on vaccine use was out of sequence. This paragraph should have preceded the five recommendations listed on page 6.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

1

REPORTING PERIOD - 13/5/82 - 26/5/82 BULLETIN NUMBER - 82/11

VIRAL IDENTIFICATIONS FROM CONTRIBUTING LABORATORIES

VIRUS OR VIRAL ANTIGEN	ICPMR (NSW)/ WVH (ACT)	RAHC (NSW)	PHB/ POW (NSW)	FAIR-FIELD (VIC)	RCH (VIC)	IAVS (SA)	STATE LAB (QLD)	STATE LAB (WA)	Total
0100 ADENOVIRUS NOT TYPED	14		2			2	7	2	27
0101 ADENOVIRUS TYPE 1	1			1	1	1		1	5
0102 ADENOVIRUS TYPE 2					3	1		1	5
0103 ADENOVIRUS TYPE 3	1								1
0105 ADENOVIRUS TYPE 5						1			1
0106 ADENOVIRUS TYPE 6								1	1
0107 ADENOVIRUS TYPE 7					1	1			2
0108 ADENOVIRUS TYPE 8			1						1
0111 ADENOVIRUS TYPE 11	1								1
0119 ADENOVIRUS TYPE 19	3							1	4
0127 ADENOVIRUS TYPE 27								1	1
0131 ADENOVIRUS TYPE 31			1						1
0199 ADENOVIRUS TYPING PENDING			1		1	3			5
0201 INFLUENZA A VIRUS			1					2	3
0203 INFLUENZA B VIRUS	1	1	3	3			1	1	10
0301 PARAINFLUENZA VIRUS TYPE 1				1	6		1		8
0302 PARAINFLUENZA VIRUS TYPE 2		1		6	11	5			23
0303 PARAINFLUENZA VIRUS TYPE 3								1	1
0399 PARAINFLUENZA VIRUS TYPING PENDING						1	3		4
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	22	23	4	3	13	19	45	2	131
0500 RHINOVIRUS (ALL TYPES)	3			3	4	1	1		12
0600 MYCOPLASMA PNEUMONIAE	28	2	6		1	5	8	5	55
0700 ORNITHOSIS-PSITTACOSIS	2		3	2		2		1	10
0809 COXSACKIEVIRUS A9	1								1
0902 COXSACKIEVIRUS B2								1	1
0904 COXSACKIEVIRUS B4						1			1
0905 COXSACKIEVIRUS B5				1	2		1		4
1006 ECHOVIRUS TYPE 6	1			1					2
1011 ECHOVIRUS TYPE 11								3	3
1013 ECHOVIRUS TYPE 13	1								1
1017 ECHOVIRUS TYPE 17				1		1			2
1022 ECHOVIRUS TYPE 22				1					1

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

2

REPORTING PERIOD - 13/5/82 - 26/5/82 BULLETIN NUMBER . 82/11

VIRAL IDENTIFICATIONS FROM CONTRIBUTING LABORATORIES-CONTINUED

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
1024 ECHOVIRUS TYPE 24								1	1
1028 ECHOVIRUS TYPE 28=RHINOVIRUS	1								1
1030 ECHOVIRUS TYPE 30	1								1
1101 POLIOVIRUS TYPE 1			1						1
1102 POLIOVIRUS TYPE 2			1					2	3
1103 POLIOVIRUS TYPE 3		1				1		1	3
1200 MUMPS VIRUS	14	2		5		1	4	2	28
1300 HERPES VIRUS GROUP-NOT TYPED	44		1	1	1	1			48
1301 HERPES SIMPLEX VIRUS NOT-TYPED		3						51	54
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	10							3	13
1303 VARICELLA-ZOSTER VIRUS	5		2		1	1		2	11
1306 HERPES SIMPLEX TYPE 1	7			16		8	15		46
1307 HERPES SIMPLEX TYPE 2	76			36		5	26		143
1399 HERPES VIRUS TYPING PENDING			10		3	2			15
1401 COXIELLA BURNETI	6		1				8		15
1502 PICORNA VIRUS-NOT TYPED	2						1		3
1512 VACCINIA VIRUS				1					1
1521 MEASLES VIRUS	6		1		1	2	2		12
1522 RUBELLA VIRUS				6	1		1	1	9
1532 HEPATITIS B ANTIGEN	8	1	3	28		7	2	4	53
1535 HEPATITIS A ANTIBODY	6		6			4	3	10	29
1541 CHLAMYDIA A - C TRACHOMATIS	38		3			2		75	118
1558 CMV - CYTOMEGALOVIRUS	15			7	3	4	5	2	36
1564 ROTAVIRUS	2	2	9		16	23		3	55
1599 ENTEROVIRUS TYPING PENDING			1		4	1			6
ROSS RIVER VIRUS							43	12	55
ASTROVIRUS	1								1
SMALL VIRUS (LIKE) PARTICLE	1								1
DENGUE							16		16
Total	322	36	61	123	73	106	195	192	1,108

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

3

PERIOD : 13/5/82 to 26/5/82 .... 82/11

Viral Identifications by Clinical Information Table 1.
Code 00,99 -No ill or data; 01,02,11,12 -Respiratory; 03 -Encephalitis; 03 -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
0101 ADENOVIRUS TYPE 1.....	1	3									
0102 ADENOVIRUS TYPE 2.....		3					2				
0105 ADENOVIRUS TYPE 5.....							1				
0131 ADENOVIRUS TYPE 31.....			1								
0201 INFLUENZA A VIRUS.....		3									
0203 INFLUENZA B VIRUS.....		7									1
0301 PARAINFLUENZA VIRUS TYPE 1....		7									1
0302 PARAINFLUENZA VIRUS TYPE 2....		21				1					
0303 PARAINFLUENZA VIRUS TYPE 3....			1								
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....	3	127									
0500 RHINOVIRUS (ALL TYPES).....		11									1
0600 MYCOPLASMA PNEUMONIAE.....	5	45									1
0700 ORNITHOSIS-PSITTACOSIS.....	3	3									
0809 COXSACKIEVIRUS A9.....	1										
0904 COXSACKIEVIRUS B4.....							1				
0905 COXSACKIEVIRUS B5.....				1			2				
1006 ECHOVIRUS TYPE 6.....		1		1							
1011 ECHOVIRUS TYPE 11.....				2		1					
1013 ECHOVIRUS TYPE 13.....							1				
1017 ECHOVIRUS TYPE 17.....							1				1
1022 ECHOVIRUS TYPE 22.....		1									
1028 ECHOVIRUS TYPE 28=RHINOVIRUS..		1									
1030 ECHOVIRUS TYPE 30.....						1					
1101 POLIOVIRUS TYPE 1.....							1				
1102 POLIOVIRUS TYPE 2.....							1				
1103 POLIOVIRUS TYPE 3.....		1					1				
1200 MUMPS VIRUS.....	10	1	1	6							

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

4

PERIOD : 13/5/82 to 26/5/82 ....

82/11

Viral Identifications by Clinical Information Table 1.
Code 00,99 -No ill or data; 01,02,11,12 -Respiratory; E3 -Enceph-alitis; M3 -Meningitis; 04 -Paralysis; 05,13 -CNS other unspec.; 07,49 -GI; 17,47 -Hepatic; 19 -CVS; 89 -Urinary; 06 -Skin/mucous.-CONTINUED

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
1301 HERPES SIMPLEX VIRUS NOT-TYPED	5										42
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	3							1			
1303 VARICELLA-ZOSTER VIRUS	2		1	1	1						6
1306 HERPES SIMPLEX TYPE 1	1	1					1			1	27
1307 HERPES SIMPLEX TYPE 2											7
1401 COXIELLA BURNETI	6								1		
1502 PICORNA VIRUS-NOT TYPED							1				
1512 VACCINIA VIRUS											1
1521 MEASLES VIRUS	2		1	2		1					5
1522 RUBELLA VIRUS	2										4
1532 HEPATITIS B ANTIGEN	24							27			2
1535 HEPATITIS A ANTIBODY	2							26			
1556 CMV - CYTOMEGALOVIRUS	16	5				2		2		2	
1564 ROTAVIRUS							55				
ROSS RIVER VIRUS	6										19
ASTROVIRUS							1				
SMALL VIRUS (LIKE) PARTICLE							1				
DENGUE	1										14
Total	93	241	5	13	1	6	70	56	1	3	132

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

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PERIOD : 13/5/82 to 26/5/82 ... 82/11

Viral Identifications by Clinical Information Table 2.
Code 10 -Eye; 59 -Genital; 39 -Endo/sal gland;
38 -RES; 29 -Muscle/joint; 69 -Congenital; P8 -PUO;
G8 -Fever/malaise; 09 -Other; A1 -SIDS ...

VIRUS OR VIRAL ANTIGEN	Eye	Genital	Endo/sal gland	RES	Muscle/joint	Congenital	PUO	Fever/malaise	Other	SIDS
0101 ADENOVIRUS TYPE 1.....									1	
0103 ADENOVIRUS TYPE 3.....	1									
0106 ADENOVIRUS TYPE 6.....										1
0107 ADENOVIRUS TYPE 7.....	1						1			
0108 ADENOVIRUS TYPE 8.....	1									
0111 ADENOVIRUS TYPE 11.....	1									
0119 ADENOVIRUS TYPE 19.....	3	2								
0127 ADENOVIRUS TYPE 27.....		1								
0203 INFLUENZA B VIRUS.....							1	1	1	
0302 PARAINFLUENZA VIRUS TYPE 2....								1		
0490 RESPIRATORY SYNCYTIAL VIRUS (RS).....									1	
0600 MYCOPLASMA PNEUMONIAE.....							1	2	1	
0700 ORNITHOSIS-PSITTACOSIS.....			1				1	2		
0902 COXSACKIEVIRUS B2.....								1		
0905 COXSACKIEVIRUS B5.....						1				
1024 ECHOVIRUS TYPE 24.....							1			
1102 POLIOVIRUS TYPE 2.....										2
1103 POLIOVIRUS TYPE 3.....										1
1200 MUMPS VIRUS.....			13							
1301 HERPES SIMPLEX VIRUS NOT-TYPED		13								
1302 EPSTEIN-BARR VIRUS (EB VIRUS).			7						2	
1303 VARICELLA-ZOSTER VIRUS.....									1	
1306 HERPES SIMPLEX TYPE 1.....	1	15								
1307 HERPES SIMPLEX TYPE 2.....		137								
1401 COXIELLA BURNETI.....								8	1	
1521 MEASLES VIRUS.....					1				1	
1522 RUBELLA VIRUS.....	1					2			1	

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE 6

PERIOD : 13/5/82 to 26/5/82 ... 82/11

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 ... -CONTINUED

VIROS OR VIRAL ANTIGEN	Eye	Genital	Endo/sal gland	RES	Muscle/joint	Congenital	PUO	Fever/malaise	Other	SIDS
1535 HEPATITIS A ANTIBODY.....									1	
1541 CHLAMYDIA A - C TRACHOMATIS...	2	116								
1556 CMV - CYTOMEGALOVIRUS.....						2	2	1	3	2
ROSS RIVER VIRUS					47			2		
DENGUE					8			9		
Total.....	10	284	21		56	5	7	27	14	6

NOTIFIABLE DISEASES REPORTED IN AUSTRALIA

3rd 4 Weekly Period for 1982
(28.2.82 to 27.3.82 inclusive)

Bulletin 82/11

Disease	N.S.W.	VIC	QLD	S.A.	W.A.	TAS.	N.T.	A.C.T.	Total	CUMULATIVE TOTAL TO DATE FOR YEAR
Amoebiasis	N.N.	1		1					2	7
Ankylostomiasis	N.N.								—	5
Anthrax									—	—
Arbovirus infection	9	9		4					22	23
Brucellosis	3			2					5	10
Campylobacter infections	N.N.	N.N.	N.N.	29	1	N.N.	3	N.N.	33	108
Chancroid			2	N.N.		N.N.	N.N.		2	4
Cholera									—	—
Congenital rubella syndrome	N.N.	N.N.	N.N.		N.N.	N.N.	N.N.	N.N.	—	—
Diphtheria									—	—
Donovanosis		N.N.	2	N.N.		N.N.	2		4	17
Giardiasis	N.N.	N.N.	N.N.	71	N.N.	N.N.	N.N.	N.N.	71	178
Genital herpes	N.N.	N.N.	N.N.	N.N.	N.N.	N.N.	3	N.N.	3	37
Gonococcal ophthalmia neonatorum		N.N.			N.N.	N.N.	N.N.	N.N.	—	—
Gonorrhoea	398	229	113	89	157	17	72	26	1101	3142
Hepatitis A (infectious)	50	17	12	19	6	1	2	3	110	349
Hepatitis B (serum)	8	27	3	7	4	—	1	2	52	176
Hepatitis - unspecified	N.N.	N.N.			3	N.N.	3		6	22
Hydatid disease								1	1	5
Lassa Fever	N.N.		N.N.			N.N.	N.N.	N.N.	—	—
Legionnaires disease	N.N.		N.N.	2	N.N.	N.N.	N.N.	N.N.	2	5
Leprosy		1	1		1		2		5	6
Leptospirosis		2	6			1			9	28
Lymphogranuloma venereum		N.N.	N.N.	N.N.	N.N.	N.N.			—	2
Malaria	7	11	16	5	1	1	1	1	43	121
Marburg Disease	N.N.		N.N.			N.N.	N.N.	N.N.	—	—
Meningococcal infections	N.N.	1	3	1		N.N.			5	14
Non-specific urethritis	N.N.	N.N.	N.N.	N.N.	N.N.	N.N.	N.N.	N.N.	—	152
Ornithosis		1						1	2	4
Pertussis (whooping cough)	N.N.	18	N.N.	1	N.N.	N.N.	N.N.	N.N.	19	81
Plague									—	—
Poliomyelitis									—	—
Q. fever	6		5	1	N.N.		N.N.		12	36
Rabies	N.N.	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	86	19	34	43	12	7	22	1	224	650
Shigella infections	N.N.	2	9	2	7		11	1	32	80
Smallpox									—	—
Syphilis	212	31	45	24	26	—	41	—	379	872
Tetanus		1		2					3	4
Trachoma	N.N.	N.N.			N.N.	N.N.			—	—
Tuberculosis (all forms)	35	20	26	10	16	—	—	3	110	328
Typhoid fever	3								3	8
Typhus (all forms)									—	—
Vibrio parahaemolyticus infections	N.N.	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.	N.N.	—	—

(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