ISSN 0725-3141

Communicable Diseases Intelligence

Bulletin number 82/20
Issue date: 8 October 1982

Contents:

VIRUS REPORTING SCHEME - A total of 1112 reports were received this period. Patterns suggested by the reports included a general abatement in respiratory tract infections; - influenza A virus (66 reports compared with 100, 117 and 127 for the previous three periods); influenza B virus (60 compared with 114, 133 and 143); respiratory syncytial virus (70 compared with 113, 104 and 157) and M. pneumoniae (65 compared with 86, 108 and 86). The seasonal rise in infantile gastroenteritis due to rotavirus infections has also subsided (40 compared with 69, 119 and 80).

- The State Health Laboratory Services, Perth, reported a further 30 cases of echovirus type 11 infection, of which 23 were in infants aged less than one year. Twelve patients presented with aseptic meningitis.

- The number of indigenous dengue cases reported by the State Health Laboratory, Brisbane, has decreased in recent reporting periods (5 compared with 1, 3 and 17). This reduction has been influenced by the past dry season (July-September) and the initiation of mosquito surveillance and control measures coupled with public health education programs. From 1 January-31 August 1982, WHO, Western Pacific Region, Manila, has confirmed dengue haemorrhagic fever (DHF) in the Philippines (31 cases; 4 deaths), Malaysia (262 cases; 11 deaths) and Singapore (99 cases). From January-May 1982, 1800 clinical cases of DHF were diagnosed in the Solomon Islands, where dengue virus type 3 has been isolated. Aedes albopictus is the primary vector.

Other reports of interest include:

- The outbreak of acute haemorrhagic conjunctivitis (AHC) which swept over large parts of the world in 1981 is still spreading in the South Pacific (WER (1982) 57 : 302). In 1982, cases continued to occur in Tonga in June (45 cases), July (65) and during the first three weeks of August (25). An outbreak of AHC was also occurring in French Polynesia in July. Vanuatu reported an outbreak which began in mid-May and was fading out in August. As of 10 August, 525 cases had been reported. The majority of the 207 patients who were investigated further fell into the age group 15-44 years. Four of five conjunctival swabs investigated were negative, and the fifth showed secondary bacterial infection.

The Bulletin is compiled and distributed by the Environmental Health Branch, Department of Health, P.O. Box 100, Woden, A.C.T. 2606, Australia, and is available on request.

GONOCOCCAL SURVEILLANCE - AUSTRALIA (JULY 1981 - JUNE 1982)

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

Since its inception in July 1981, the AGSP has collated the national prevailing penicillin sensitivities of N. gonorrhoeae isolates on a quarterly basis. Previous reports were published in CDI 81/25, 82/5 and 82/11. This article reviews those three periods and incorporates the data (1448 isolates) gathered from the participating laboratories for the recent quarter April-June 1982 (Table 1). A bimodal distribution for the penicillin sensitivities of the isolates was observed in each of the four surveys, with strains falling into one of two categories - "sensitive" (minimal inhibitory concentration (MIC) values - 0.008 µg/ml) or "decreased sensitivity (MIC - 0.12 µg/ml).

TABLE 1 Penicillin sensitivity of N. gonorrhoeae isolates July 1981 - June 1982

Source	Percentage of isolates							
	1981				1982			
	July - Sept		Oct. - Dec.		Jan. - Mar.		Apr. - June	
	A	B	A	B	A	B	A	B
Perth	50.1	33.1	45.3	20.7	37.4	34.5	31.3	42.1
Adelaide	40.0	43.9	35.4	55.3	35.8	55.7	30.0	45.2
Melbourne	45.3	45.0	45.7	40.3	31.9	43.6	44.6	42.4
Sydney	18.7	66.3	25.4	53.0	27.2	60.4	28.9	57.9
Brisbane	52.0	42.0	37.4	55.2	37.6	46.0	31.1	50.0
Australia	40.5	45.3	38.0	44.9	32.3	48.3	37.0	46.7

A - MIC = 0.008 µg/ml ± one doubling dilution

B - MIC = 0.12 µg/ml ± one doubling dilution

The use of standardised methods (see CDI 81/4) and consistent reporting by the AGSP participating laboratories has allowed a comparative analysis of the results for the 12 months. In Melbourne, the numbers of strains in the two categories remained approximately constant. On the other hand, in Adelaide, Brisbane and recently Perth, the ratio of the sensitive to decreased sensitivity categories fell, with the result that less-sensitive gonococci currently predominate in the three centres. This pattern of a decreased sensitivity prevalence was also evident in Sydney, where it emerged in the 12 months prior to the commencement of the survey in July 1981.

The isolation percentages of penicillinase-producing N. gonorrhoeae (PPNG) strains also varied between centres and quarterly periods (Table 2).

TABLE 2. Percentages of PPNG strains isolated by AGSP participating laboratories. July 1981-June 1982.

Source	1981		1982	
	July - Sept	Oct - Dec	Jan - Mar	Apr - June
Perth	4.2	11.5	7.2	5.8
Adelaide	0.8	2.9	0.07	1.9
Melbourne	1.1	3.0	3.2	0.08
Sydney	1.6	7.0	3.9	7.0
Brisbane	1.7	4.9	7.8	6.7
Australia	2.0	4.9	4.1	2.3

The percentage of PPNG isolations was consistently high in Perth and low in Adelaide and Melbourne. Brisbane and Sydney recorded increasing numbers of PPNG strains throughout the 12 months. Most of the patients acquired their infection overseas, particularly Manila in the Philippines. Several locally-acquired infections were recorded in Sydney in the quarter April - June 1982.

Strains of penicillin-resistant (MIC value $\leqslant$ 1.0 ug/ml), non-penicillinase-producing gonococci were infrequent, and accounted for only 1-2% of the total isolates in each survey period.

Editorial Comment.

The number of PPNG cases reported in developed countries has risen significantly in the past two years (see Table 3).

TABLE 3. Incidence of PPNG in Australia, UK, USA and Canada

Year	Australia	UK	USA	Canada
1980	144	311	1099	23
1981	177	443	2734	33
1982	96 (Jan-June)	420 (Jan-June)[1]	1323 (Jan-Apr)[2]	37 (Jan-June)[3]

In the UK, 58% of the 420 cases reported in 1982 (Table 3) acquired their infection within the country[1]. Although sustained domestic transmission is also a problem in the USA, auxotyping and serogrouping of isolates from outbreaks have shown that they resulted from imported strains rather than from the spread of penicillinase-coding plasmids to indigenous gonococci[4].

Endemic areas of PPNG exist in the Far East and West Africa. The "Asian" type isolates are characterised by a 4.5 megadalton plasmid and 24.5 megadalton transfer plasmid, whereas the "African" types only carry a 3.2 megadalton plasmid. In June 1980, a new plasmid combination comprising the 3.2 megadalton plasmid and 24.5 megadalton transfer plasmid was reported in the Netherlands[5]. By March-April 1981, this new type constituted about 80% of all PPNG strains isolated suggesting some selective advantage over the other PPNG strains. Strains with this new combination have also been detected in Canada[3] and the UK[6].

To date outbreaks of PPNG infection, even within high-risk groups, have appeared to respond to aggressive public health intervention and containment, so minimising sustained domestic transmission. Medical practitioners and clinicians should always be aware of the need to ensure clinical and bacteriological cure of patients presenting with gonorrhoea, and the rapid treatment of their sexual contacts.

Spectinomycin-resistant gonococci are uncommon. The total number of reported cases is now ten, six in PPNG strains[7,8,9], and four in non-PPNG strains. In the second, third and fourth cases, spectinomycin-resistant strains were not isolated until the patients were treated with spectinomycin, and in one instance a PPNG strain could only be isolated after ampicillin/probenecid treatment. Although the emergence of spectinomycin resistance could be the result of either selection or induction, the increasing MIC values for spectinomycin observed for the isolates in the second reported case favour induced chromosomal resistance.

References

1. CDR (1982) 82/34 : 6
2. NEJM (1982) 307 : 438
3. CDWR (1982) 8/29 : 141
4. NEJM (1982) 306 : 950
5. WER (1981) 56 : 221
6. CDR (1982) 82/09 : 1
7. MMWR (1981) 30 : 221
8. CDR (1981) 81/49 : 1
9. CDR (1982) 82/37 : 4

POTENTIAL SYPHILIS OUTBREAK IN A NURSERY
(Based on California Morbidity (1982) #37)

On 11 January 1982, an employee in the newborn nursery at the Kern Medical Center, Bakersfield, California, was diagnosed as having secondary syphilis. The patient first noted a rash on her arms about 8 December 1981, but as she had just started using a new detergent, she initially considered the rash to be a sensitivity reaction. During the next two weeks, the rash spread to her lower extremities, palms and soles. Malaise and mild lymphadenopathy developed. She consulted her general practitioner who suspected syphilis. Serology performed on 11 January showed a Venereal Disease Research Laboratory (VDRL) titre of 1/128 and a fluorescent treponemal antibody absorption (FTA-ABS) of + 3. The patient was treated with two 2.4 mega units Bicillin injections. Investigation revealed that her steady sexual partner had been diagnosed as having primary syphilis in late October, but to avoid embarressment and because of her nursery connection, the patient had not named the employee as a contact nor informed her of his infection.

Advice was sought from Centers for Disease Control, and four alternatives were suggested.

- Serological testing all exposed infants at six weeks of age and again eight weeks later, treating positives whenever discovered.
- Same as above suggestion, but treat all infants for whom compliance problems may delay the second test.
- Treat all infants without any serodiagnosis efforts.
- Treat only infants at higher risk (those whom the employee might have actually handled).

CDC consultants indicated that the exposure risk was small except for possible contamination of circumcisions or umbilical cords. Because there was no way of determining those at "high-risk", it was decided to promptly test all 252 newborns who were in the nursery while the employee was infectious, and to retest them in two months, treating any positives discovered.

Letters were sent to all mothers by certified mail. Lists of the infant's names were provided to all area paediatric/well baby clinics, and local private practitioners were notified and given a special patient referral source. Public health nurses assisted in locating parents who did not respond to the mailing within three weeks. By 18 March, 247 infants had been tested; all were seronegative. Of the remaining five, one was in Mexico, one was not located, one had died of non-syphilitic causes, and two were being followed by their private practitioners. The repeat testing commenced in early April. By mid-July, of the 252 infants, 227 were still seronegative, eight were under private care but were reported to be negative, two were out-of-State and were still being sought, one had died and 14 were lost to follow-up investigation.

The following conclusions and recommendations can be drawn from the above aggressive "contact-tracing" and epidemiological evaluation.

- The presence of a secondary syphilis staff case in a well run nursery appears to be associated with a very low transmission risk for patients.

- In large nurseries, a true cohorting system of infants and personnel (i.e. consistent assignment of staff members to infants to specific parts of the nursery) would facilitate determination of infants at highest risk of infection in outbreaks or potential outbreaks of person-to-person transmitted illnesses.

- In contacts with families of potentially exposed infants and with news media, frank and specific discussion of the disease involved and its consequences can avoid confusion and speed compliance.

PROBLEMS WITH CANNED CANADIAN AND UNITED STATES SALMON

(Based on CDWR (1982) 8/37 : 181)

Early in February 1982, a Belgian couple became ill as a result of botulism. The husband subsequently died. The intoxication was traced to a 220 g can of salmon processed in Alaska. *Clostridium botulinum* type E apparently contaminated the can contents after heat processing through a 0.5 cm diameter hole in the can body which was covered by the label. The hole was caused by a malfunction of equipment used to form cans before filling.

The illness prompted a health alert in all countries importing US canned salmon. In the United States, the Food and Drug Administration, in cooperation with the food industry, advised consumers to examine 220 g cans for holes or other obvious defects and return such cans to the place of purchase. Following this public warning, the same defect was found in canned salmon produced by other Alaskan canners. This resulted in a recall throughout the world of a total of more than 50 million cans representing almost 20% of the 1980 and 1981 canned salmon production. This recall action had a severe economic impact on the Alaskan industry and reduced consumer confidence in the product.

Because of concern about the US product, salmon importing companies in the UK began examining cans of Canadian salmon. Three cans with holes similar to those in the US cans and an unacceptably high number of seam defects were found in 1981 shipments. At the same time, two incidents of illness were reported in which Canadian salmon was eaten as part of a meal. On 23 April, the UK Department of Health and Social Services issued a public warning against the consumption of Canadian salmon in 220 g cans. As a result of this action, and the previous warning against the US product, sales of North American canned salmon packed in 220 g cans were effectively stopped. By May, over 15 incidents of foodborne illness were recorded in which Canadian salmon was part of the meal. However, further epidemiological evidence implicating Canadian salmon was not uncovered in any of the incidents, nor were illness-causing microorganisms isolated from the salmon or the patients, nor were defects found in any of the empty cans recovered.

In Canada, as a result of this problem, officers from the Health Protection Branch and Fisheries and Oceans, visually examined over 300 000 cans from the 1981 lots produced by all 17 Canadian canneries and stored in warehouses. Unacceptably high levels of seam defects were found in some lots from four manufacturers with two canneries being responsible for over 60% of all defects found. Subsequent to this information, Australia and New Zealand recalled Canadian canned salmon produced by the two companies. The number of cans from the lots with defective product on the Canadian market was low and no illnesses were reported in association with consumption of salmon in 220 g cans. However, because of the potential hazard to the public of even a few contaminated cans, Health and Welfare Canada announced on 14 May that consumers should examine all 220 g cans of Canadian salmon for holes and evidence of leakage or spoilage. Officers from Fisheries and Oceans and the salmon industry visited Australia and New Zealand to supervise sorting of cans, to ensure that only a sound product would be put on sale. As a result of this action, the ban on sale of salmon canned by these companies was lifted.

Representatives from Fisheries and Oceans, and Health and Welfare also met with government officials and canned salmon importers in the UK, and a satisfactory means for detecting and removing defective cans was devised. This is now being applied to product for both domestic and export markets. On 26 July, the UK allowed Canadian and US canned salmon already in that country and sorted by the above means, to be sold.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD - 16/9/82 — 29/9/82 BULLETIN NUMBER . 82/20

VIRAL IDENTIFICATIONS FROM CONTRIBUTING LABORATORIES

VIRUS OR VIRAL ANTIGEN	ICPMR (NSW)/ WVH (ACT)	RAHC (NSW)	PHH/ POW (NSW)	FAIR-FIELD (VIC)	RCH (VIC)	IMVS (SA)	STATE LAB (QLD)	STATE LAB (WA)	Total
0100 ADENOVIRUS NOT TYPED	3	1			1	2	4	5	16
0101 ADENOVIRUS TYPE 1	3	1				1			5
0102 ADENOVIRUS TYPE 2	1		1			4		1	7
0103 ADENOVIRUS TYPE 3		1						1	2
0105 ADENOVIRUS TYPE 5	2			1					3
0109 ADENOVIRUS TYPE 9								1	1
0110 ADENOVIRUS TYPE 10								1	1
0119 ADENOVIRUS TYPE 19			1						1
0131 ADENOVIRUS TYPE 31			1						1
0199 ADENOVIRUS TYPING PENDING		2	3		2	2			9
0201 INFLUENZA A VIRUS	12		2	7		16	7	5	49
0202 INFLUENZA A VIRUS SUBTYPE H3N2	7	1		5	1		3		17
0203 INFLUENZA B VIRUS	13		5	6	1	9	17	9	60
0301 PARAINFLUENZA VIRUS TYPE 1	1						1		2
0302 PARAINFLUENZA VIRUS TYPE 2								3	3
0303 PARAINFLUENZA VIRUS TYPE 3				1		1	5	1	8
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	3	8	3	9	9	5	8	25	70
0500 RHINOVIRUS (ALL TYPES)				5	7	1	6	2	21
0600 MYCOPLASMA PNEUMONIAE	26	3	6	4		3	15	11	68
0700 ORNITHOSIS-PSITTACOSIS			2	1		1			4
0809 COXSACKIEVIRUS A9	1			2					3
0905 COXSACKIEVIRUS B5							1		1
1004 ECHOVIRUS TYPE 4				1					1
1011 ECHOVIRUS TYPE 11								30	30
1017 ECHOVIRUS TYPE 17	1								1
1018 ECHOVIRUS TYPE 18				2				1	3
1021 ECHOVIRUS TYPE 21								1	1
1030 ECHOVIRUS TYPE 30								1	1
1101 POLIOVIRUS TYPE 1							1	1	2
1102 POLIOVIRUS TYPE 2						1			1
1104 POLIOVIRUS-VACCINAL STRAIN	1		1						2
1200 MUMPS VIRUS	15	3		1		2	4	3	28
1300 HERPES VIRUS GROUP-NOT TYPED	24			5		5		2	36
1301 HERPES SIMPLEX VIRUS NOT-TYPED		3		5			1	45	54
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	2		3	1				2	8
1303 VARICELLA-ZOSTER VIRUS	3					1			4
1306 HERPES SIMPLEX TYPE 1	7	2	11	19		9	19		67
1307 HERPES SIMPLEX TYPE 2	66		19	32		12	27		156
1399 HERPES VIRUS TYPING PENDING			2		6	1			9
1401 COXIELLA BURNETI	6			2		2	5		15
1515 CONTAGIOUS PUSTULAR DERMATITIS (ORF VIRUS)				1					1
1521 MEASLES VIRUS	6			7		1	1	1	16
1522 RUBELLA VIRUS	2		5	4				3	14
1532 HEPATITIS B ANTIGEN	21		7	34		12	4	5	83
1535 HEPATITIS A ANTIBODY	1			5		11	1	7	25
1541 CHLAMYDIA A - C TRACHOMATIS	26		4			1		45	76
1556 CMV - CYTOMEGALOVIRUS	11	1	2	21	3	5	2	6	51
1564 ROTAVIRUS		7	14	8	4	5	2		40
1599 ENTEROVIRUS TYPING PENDING	2	7	8		8				25
ROSS RIVER VIRUS							2		2
SMALL VIRUS (LIKE) PARTICLE				1					1
DENGUE							5		5
KUNJIN VIRUS							2		2
Total	266	40	100	190	42	113	143	218	1,112

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 16/9/82 to 29/9/82 .... 82/20

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.

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		4									1
0102 ADENOVIRUS TYPE 2	1	4					2				
0103 ADENOVIRUS TYPE 3		1				1					
0105 ADENOVIRUS TYPE 5	1	2									
0131 ADENOVIRUS TYPE 31							1				
0201 INFLUENZA A VIRUS	3	33							2		
0202 INFLUENZA A VIRUS SUBTYPE H3N2	1	15				1					
0203 INFLUENZA B VIRUS	1	43			1				5		3
0301 PARAINFLUENZA VIRUS TYPE 1		2									
0302 PARAINFLUENZA VIRUS TYPE 2		2									
0303 PARAINFLUENZA VIRUS TYPE 3	1	7									
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	5	63									
0500 RHINOVIRUS (ALL TYPES)		19					2				
0600 MYCOPLASMA PNEUMONIAE	10	46		1					1		2
0700 ORNITHOSIS-PSITTACOSIS	1	3									
0809 COXSACKIEVIRUS A9		1		2							
0905 COXSACKIEVIRUS B5				1							
1004 ECHOVIRUS TYPE 4		1		1							
1011 ECHOVIRUS TYPE 11	9	4		12		2	1				
1017 ECHOVIRUS TYPE 17											1
1018 ECHOVIRUS TYPE 18	1										1
1021 ECHOVIRUS TYPE 21	1										
1101 POLIOVIRUS TYPE 1		1									
1102 POLIOVIRUS TYPE 2		1									
1104 POLIOVIRUS-VACCINAL STRAIN	1						1				
1200 MUMPS VIRUS	3	2		8						1	
1301 HERPES SIMPLEX VIRUS NOT-TYPED		1	1					1	1	2	32
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	1							1		1	
1303 VARICELLA-ZOSTER VIRUS	1										1
1306 HERPES SIMPLEX TYPE 1	1	3		1							
1307 HERPES SIMPLEX TYPE 2											5
1401 COXIELLA BURNETI	3	1						1			
1515 CONTAGIOUS PUSTULAR DERMATITIS (ORF VIRUS)											1
1521 MEASLES VIRUS	1	1	1			1	1				11
1522 RUBELLA VIRUS	1						1				10
1532 HEPATITIS B ANTIGEN	32	1						47			
1535 HEPATITIS A ANTIBODY	4							18			
1556 CMV - CYTOMEGALOVIRUS	6	13		1			1	2		7	1
1564 ROTAVIRUS		1					39				
SMALL VIRUS (LIKE) PARTICLE							1				
DENGUE											2
KUNJIN VIRUS	1										
Total	90	275	2	27	1	5	50	70	9	11	112

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 16/9/82 to 29/9/82. ... 82/20
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
0103 ADENOVIRUS TYPE 3.....				1						
0109 ADENOVIRUS TYPE 9.....	1									
0110 ADENOVIRUS TYPE 10.....		1								
0119 ADENOVIRUS TYPE 19.....	1									
0201 INFLUENZA A VIRUS.....			1				3	6	2	
0202 INFLUENZA A VIRUS SUBTYPE H3N2								3		
0203 INFLUENZA B VIRUS.....			1		2		3	10		
0302 PARAINFLUENZA VIRUS TYPE 2....								1		
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....				1			2	5		
0500 RHINOVIRUS (ALL TYPES).....								2	1	1
0600 MYCOPLASMA PNEUMONIAE.....					1		1	7	1	
0809 COXSACKIEVIRUS A9.....								1		
1011 ECHOVIRUS TYPE 11.....							2	2		
1017 ECHOVIRUS TYPE 17.....								1		
1018 ECHOVIRUS TYPE 18.....	1									
1030 ECHOVIRUS TYPE 30.....								1		
1101 POLIOVIRUS TYPE 1.....								1		
1200 MUMPS VIRUS.....			14				1			
1300 HERPES VIRUS GROUP-NOT TYPED..		1								
1301 HERPES SIMPLEX VIRUS NOT-TYPED	1	16				1		1	1	
1302 EPSTEIN-BARR VIRUS (EB VIRUS).			1	1				2	2	
1306 HERPES SIMPLEX TYPE 1.....	3	17	1					5	3	
1307 HERPES SIMPLEX TYPE 2.....		151								
1401 COXIELLA BURNETI.....							2	6	2	
1521 MEASLES VIRUS.....				1					1	
1522 RUBELLA VIRUS.....					1				4	
1532 HEPATITIS B ANTIGEN.....					1				3	
1535 HEPATITIS A ANTIBODY.....									3	
1541 CHLAMYDIA A - C TRACHOMATIS...	1	75								
1556 CMV - CYTOMEGALOVIRUS.....		5	1	1	1	5		4	6	
ROSS RIVER VIRUS					2					
DENGUE					2			3		
KUNJIN VIRUS								1		
Total.....	8	266	19	5	10	6	14	62	29	1

NOTIFIABLE DISEASES REPORTED IN AUSTRALIA

8 th 4 Weekly Period for 1982
(18.7.82 to 14.8.82 inclusive)

Bulletin 82/20

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	14
Ankylostomiasis			2						2	66
Anthrax									—	—
Arbovirus infection		1							1	56
Brucellosis	1						1		2	21
Campylobacter infections	4	N.N.	N.N.	25	N.N.	N.N.	N.N.	N.N.	29	266
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									—	—
Donovanosis		N.N.	4	N.N.		N.N.	1		5	67
Giardiasis	4	N.N.	N.N.	27	N.N.	N.N.	N.N.	N.N.	31	388
Genital herpes	1	N.N.	N.N.	21	N.N.	N.N.		N.N.	22	235
Gonococcal ophthalmia neonatorum		N.N.			N.N.	N.N.	N.N.	N.N.	—	1
Gonorrhoea	300	378	54	63	75	8	38	16	932	8020
Hepatitis A (infectious)	23	29	6	11	4	2	3		78	790
Hepatitis B (serum)	23	27	6	6	2				64	511
Hepatitis - unspecified	4	N.N.		1	5	N.N.	N.N.		10	80
Hydatid disease		1		— 1		1			1	9
Lassa Fever			N.N.			N.N.	N.N.	N.N.	—	—
Legionnaires disease			N.N.		N.N.	N.N.	N.N.	N.N.	—	10
Leprosy			1		1				2	22
Leptospirosis	1			2					3	57
Lymphogranuloma venereum		N.N.	N.N.	N.N.	N.N.	N.N.		- 2	- 2	1
Malaria	4	9	21	2					36	324
Marburg Disease			N.N.			N.N.	N.N.	N.N.	—	—
Meningococcal infections	1	1	1	1		N.N.		1	5	43
Non-specific urethritis	7	N.N.	N.N.	144	N.N.	N.N.	N.N.	N.N.	151	930
Ornithosis									—	10
Pertussis (whooping cough)	1	4	N.N.		N.N.	N.N.	N.N.	N.N.	5	138
Plague									—	—
Poliomyelitis									—	—
Q. fever	11		4	5	N.N.		N.N.		20	132
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	5	6	15	15	2	2	12	7	64	1426
Shigella infections	1	3	3	6	3	2	15	—	33	277
Smallpox									—	—
Syphilis	115	10	18	7	15	1	29	—	195	2016
Tetanus									—	8
Trachoma		N.N.			N.N.	N.N.			—	—
Tuberculosis (all forms)	30	27	17	15	20	—	5	3	117	832
Typhoid fever									—	18
Typhus (all forms)									—	1
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.	—	—

(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

Hepatitis	Vic	+ 1
Malaria	Qld	+ 2
Tuberculosis	NSW	+ 1