ISSN 0725-3141

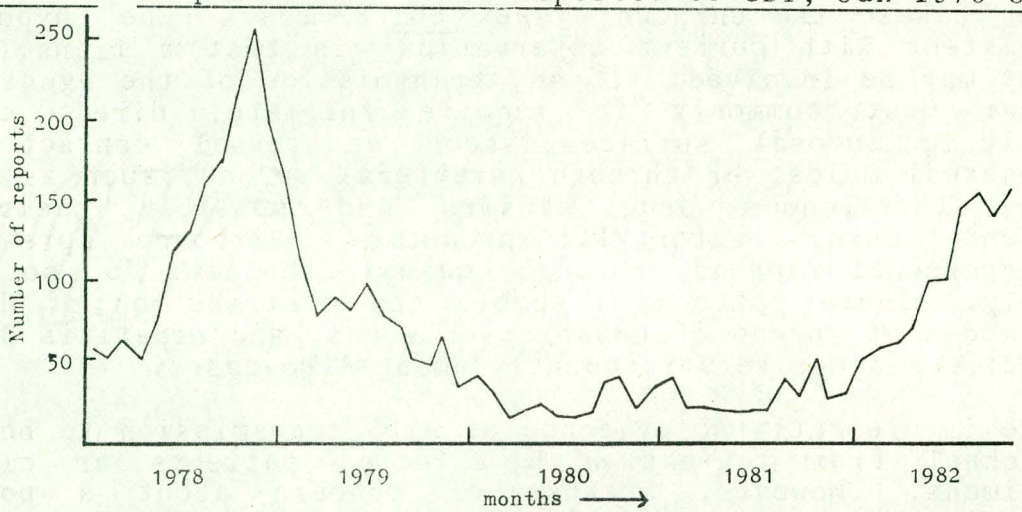
Communicable Diseases Intelligence

Bulletin number 82/24
Issue date: 3 December 1982

Contents:

VIRUS REPORTING SCHEME - A total of 1135 reports were received this period. *Mycoplasma pneumoniae* continued to be the respiratory pathogen most frequently reported (103 reports compared with 101, 77 and 66 for the previous three periods). The State Health Laboratory Services, Perth, detected specific IgM by CF test against *M. pneumoniae* in a 13 year old boy with encephalitis; and the Institute of Clinical Pathology and Medical Research (ICPMR), Sydney, reported CF antibody titres in a 17 year old male with Stevens-Johnson syndrome (four reported in 1982) and in a nine year old boy with an IgA immune deficiency. *M. pneumoniae* outbreaks tend to show a cyclic pattern, although they do not affect all parts of a region at the same time. The last outbreak ended in late-1979 (Figure 1). Reports of infection began to increase again in early-1982, initially from the ICPMR, Sydney, and the State Health Laboratory, Brisbane, and more recently from the State Health Laboratory Services, Perth.

FIGURE 1 *M. pneumoniae* cases reported to CDI; Jan 1978-Oct 1982



The age distribution of cases was fairly consistent during the 1978-82 period, exhibiting characteristic peaks in children aged 5-14 years (26-38%) and in adults aged 25-59 years (25-32%). Infection in infants less than one year were rare (⩽1%), suggesting that maternally-derived antibody is protective. Also as close contact is thought to be necessary for transmission, the slight female preponderance in the 25-59 years age group may be a reflection that children are more likely to infect their mothers than fathers.

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.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS): PRECAUTIONS FOR CLINICAL AND LABORATORY STAFFS
(Based on MMWR (1982) 31 : 507 and 577)

The Centers for Disease Control define a case of AIDS as a disease, at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known cause for diminished resistance to that disease. Such diseases comprise Kaposi's sarcoma (KS; patients under 60 years of age); Pneumocystis carinii pneumonia (PCP); serious opportunistic infections including pneumonia, meningitis or encephalitis due to one or more of aspergillosis, candidiasis, cryptococcosis, cytomegalovirus, nocardiosis, strongyloidosis, toxoplasmosis, zygomycosis or atypical mycobacteriosis (species other than M. tuberculosis or M. leprae); oesphagitis due to candidiasis, cytomegalovirus, or herpes simplex virus; progressive multifocal leucoencephalopathy; chronic enterocolitis (more than four weeks) due to cryptosporidiosis; or unusually extensive mucocutaneous herpes simplex of more than five weeks duration. Diagnoses are considered to fit the case definition only if based on sufficiently reliable methods (generally histology or culture). However, this case definition may not include the full spectrum of AIDS manifestations, which may range from absence of symptoms (despite laboratory evidence of immune deficiency) to non-specific symptoms (e.g. fever, weight loss, generalised, persistent lymphadenopathy) to specific diseases that are insufficiently portentous of cellular immunodeficiency to be included in incidence monitoring (e.g. tuberculosis, oral candidiasis, herpes zoster) or to malignant neoplasms that cause, as well as result from, immunodeficiency.

The aetiology of the underlying immune deficiencies seen in AIDS cases is unknown (see CDI 82/16). One hypothesis consistent with current observations is that a transmissible agent may be involved. If so, transmission of the agent would appear most commonly to require intimate, direct contact involving mucosal surfaces, such as sexual contact among homosexual males, or through parenteral spread, such as occurs among intravenous drug abusers and possibly haemophilia patients using Factor VIII products. Airborne spread and interpersonal spread through casual contact do not seem likely. These patterns resemble the distribution of disease and modes of spread of hepatitis B virus, and hepatitis B virus infections occur very frequently among AIDS cases.

There is presently no evidence of AIDS transmission to hospital personnel from contact with affected patients or clinical specimens. However, because of concern about a possible transmissible agent, interim suggestions are appropriate to guide patient-care (Table 1) and laboratory personnel (Table 2), including those whose work involves experimental animals (Table 3). These tables have been reproduced verbatim from the original article published in MMWR (1982) 31 : 577. At present, it appears prudent for hospital personnel to use the same precautions when caring for patients with AIDS as those used for patients with hepatitis B virus infection in which blood, and body fluids likely to have been contaminated with blood, are considered infective. Specifically, patient-care and laboratory personnel should take precautions to avoid direct contact of skin and mucous membranes with blood, blood products, excretions, secretions, and tissues of persons judged likely to have AIDS. The precautions do not specifically address outpatient care, dental care, surgery, necropsy or haemodialysis of AIDS patients. In general,

TABLE 1 Precautions recommended for clinical staff caring for AIDS patients

The following precautions are advised in providing care to AIDS patients:

- Extraordinary care must be taken to avoid accidental wounds from sharp instruments contaminated with potentially infectious material, and to avoid contact of open skin lesions with material from AIDS patients.

- Gloves should be worn when handling blood specimens, blood-soiled items, body fluids, excretions and secretions; as well as surfaces, materials and objects exposed to them.

- Gowns should be worn when clothing may be soiled with body fluids, blood secretions or excretions.

- Hands should be washed after removing gowns and gloves, and before leaving the rooms of known or suspected AIDS patients. Hands should also be washed thoroughly and immediately if they become contaminated with blood.

- Blood and other specimens should be labelled prominently with a special warning, such as "Blood Precautions" or "AIDS Precautions". If the outside of the specimen container is visibly contaminated with blood, it should be cleaned with a disinfectant (such as a 1:10 dilution of 5.25% sodium hypochlorite (household bleach) with water). All blood specimens should be placed in a second container, such as an impervious bag, for transport. The container or bag should be examined carefully for leaks or cracks.

- Blood spills should be cleaned up promptly with a disinfectant solution, such as sodium hypochlorite (see above).

- Articles soiled with blood should be placed in an impervious bag prominantly labelled "AIDS Precautions" or "Blood Precautions" before being sent for reprocessing or disposal. Alternatively, such contaminated items may be placed in plastic bags of a particular colour designated solely for disposal of infectious wastes by the hospital. Disposable items should be incinerated or disposed of in accord with the hospital's policies for disposal of infectious wastes. Reusable items should be reprocessed in accord with hospital policies for hepatitis B virus-contaminated items. Lensed instruments should be sterilised after use on AIDS patients.

- Needles should not be bent after use, but should be promptly placed in a puncture-resistant container used solely for such disposal. Needles should not be reinserted into their original sheaths before being discarded into the container, since this is a common cause of needle injury.

- Disposable syringes and needles are preferred. Only needle-locking syringes or one-piece needle-syringe units should be used to aspirate fluids from patients, so that collected fluid can be safely discharged through the needle, if desired. If reusable syringes are employed, they should be decontaminated before reprocessing.

- A private room is indicated for patients who are too ill to use good hygiene, such as those with profuse diarrhoea, faecal incontinence, or altered behaviour secondary to central nervous system infections.

Precautions appropriate for particular infections that concurrently occur in AIDS patients should be added to the above, if needed.

TABLE 2 Precautions recommended for laboratory staff handling clinical speciments from AIDS patients

The following precautions are advised for persons performing laboratory tests or studies on clinical specimens or other potentially infectious material (such as inoculated tissue cultures, embryonated eggs, animal tissues etc.) from known or suspected AIDS cases:

- Mechanical pipetting devices should be used for the manipulation of all liquids in the laboratory. Mouth pipetting should not be allowed.
- Needles and syringes should be handled as stipulated in the relevant section of Table 1.
- Laboratory coats, gowns, or uniforms should be worn while working with potentially infectious material and should be discarded appropriately before leaving the laboratory.
- Gloves should be worn to avoid skin contact with blood, specimens containing blood, blood-soiled items, body fluids, excretions and secretions; as well as surfaces, materials and objects exposed to them.
- All procedures and manipulations of potentially infectious material should be performed carefully to minimise the creation of droplets and aerosols.
- Biological safety cabinets (Class 1 or 2) and other primary containment devices (e.g., centrifuge safety cups) are advised whenever procedures are conducted that have a high potential for creating aerosols or infectious droplets. These include centrifuging, blending, sonicating, vigorous mixing, and harvesting infected tissues from animals or embryonated eggs. Fluorescent activated cell sorters generate droplets that could potentially result in infectious aerosols. Translucent plastic shielding between the droplet-collecting area and the equipment operator should be used to reduce the presently uncertain magnitude of this risk. Primary containment devices are also used in handling materials that might contain concentrated infectious agents or organisms in greater quantities than expected in clinical specimens.
- Laboratory work surfaces should be decontaminated with a disinfectant, such as sodium hypochlorite solution (a 1:10 dilution of 5.25% sodium hypochlorite with water), following any spill of potentially infectious material and at the completion of work activities.
- All potentially contaminated materials used in laboratory tests should be decontaminated, preferably by autoclaving, before disposal or reprocessing.
- All personnel should wash their hands following completion of laboratory activities, removal of protective clothing, and before leaving the laboratory.

procedures appropriate for patients known to be infected with hepatitis B virus are advised, and blood and organs of AIDS patients should not be donated.

TABLE 3 Precautions recommended for laboratory staff engaged in research using experimental animals inoculated with clinical specimens from AIDS patients

The following additional precautions are advised for studies involving experimental animals inoculated with tissues or other potentially infectious materials from individuals with known or suspected AIDS.

- Laboratory coats, gowns, or uniforms should be worn by personnel entering rooms housing inoculated animals. Certain non-human primates, such as chimpanzees, are prone to throw excreta and to spit at attendents; personnel attending inoculated animals should wear molded surgical masks and goggles or other equipment sufficient to prevent potentially infective droplets from reaching the mucosal surfaces of their mouths, noses and eyes. In addition, when handled, other animals may disturb excreta in their bedding. Therefore, the above precautions should be taken when handling them.

- Personnel should wear gloves for all activities involving direct contact with experimental animals and their bedding and cages. Such manipulations should be performed carefully to mimimise the creation of aerosols and droplets.

- Necropsy of experimental animals should be conducted by personnel wearing gowns and gloves. If procedures generating aerosols are performed, masks and goggles should be worn.

- Extraordinary care must be taken to avoid accidental sticks or cuts with sharp instruments contaminated with body fluids or tissues of experimental animals inoculated with material from AIDS patients.

- Animal cages should be decontaminated, preferably by autoclaving, before they are cleaned and washed.

- Only needle-locking syringes or one-piece needle-syring units should be used to inject potentially infectious fluids into experimental animals.

The above precautions are intended to apply to both clinical and research laboratories. Biological safety cabinets and other safety equipment may not be generally available in clinical laboratories. Assistance should be sought from a microbiological laboratory, as needed, to assure containment facilities are adequate to permit laboratory tests to be conducted safely.

ARBOVIRUS SURVEILLANCE IN THE MURRAY REGION - VICTORIA

(Contributed by J. Campbell, Attwood Veterinary Research Laboratory, Westmeadows, Melbourne; and A. Porter, Health Commission of Victoria).

During 1981, some areas of northern Victoria experienced the wettest winter for 30 years or more, resulting in extensive flooding of permanent swamps and low-lying areas. As part of the 1981-82 arbovirus surveillance program, 200 seronegative chickens were apportioned into ten sentinel flocks and established at Mildura, Robinvale, Swan Hill, Kerang, Echuca, Barmah, Shepparton, Cobram, Rutherglen and Wodonga. The birds were bled weekly throughout the official campaign (mid November - late February), and the sera tested for HI antibodies against alphavirus (Sindbis, Ross River virus (RRV)) and flavivirus (MVE, Kunjin) antigens (see CDI 82/22 for 1981-82 arbovirus surveillance program in New South Wales).

Seroconversions against alphavirus antigen were first detected at Barmah on 30 November 1981, one week after the sentinel chicken flock was sited. The dates of the first seroconversions and the total number of seropositive chickens at the end of the survey period for each locality are given in Table 1.

TABLE 1 Alphavirus seroconversion among sentinel chicken flocks (1981-82)

Location	Date of first seroconversion	Number of seropositive chickens (15 March 1982)
Barmah	30 November 1981	6
Mildura	21 December 1981	12
Cobram	28 December 1981	7
Robinvale	4 January 1982	3
Swan Hill	25 January 1982	4
Rutherglen	25 January 1982	4
Echuca	25 January 1982	5
Kerang	15 February 1982	1
Shepparton	8 March 1982	3
Wodonga	-	0
TOTAL		45

A follow-up bleed on 22 October 1982 of 14 birds in the Mildura flock showed that 13 had HI antibody against alphavirus antigen; five of these had been seronegative on 15 March 1982. Similarly, 11 chickens in the Shepparton flock, of which only two had exhibited antibody at the end of the survey period, were seropositive.

HI antibody against flavivirus antigen was detected in five flocks (Table 2). The infecting agent was confirmed to be Kunjin virus by plaque neutralisation/plaque reduction tests.

TABLE 2 Flavivirus seroconversions among sentinel chicken flocks (1981-82)

Location	Chicken	Date of serum sample	Peak HI titre	
			Kunjin	MVE
Swan Hill	1*	22 February 1982	1/640	1/20
	2*	26 February 1982	1/40	0
	3	1 March 1982	1/80	0
	4	15 March 1982	±1/20	0
Mildura	1	1 March 1982	1/40	0
	2	10 March 1982	1/80	0
	3	10 March 1982	1/80	0
	4	15 March 1982	1/40	0
	5	15 March 1982	1/320	0
Robinvale	1	5 March 1982	1/80	0
	2	5 March 1982	1/160	0
Rutherglen	1	1 March 1982	1/320	0
Barmah	1	15 March 1982	1/160	0

* Kunjin virus isolated from blood clots on 2 and 26 February 1982 respectively.

Kunjin virus was also isolated from two chicken blood clots (see Table 2), and from a pool of Culex annulirostris mosquitoes collected at Swan Hill on 22 February.

To obtain data on human transmission in the region, blood specimens were collected in November 1981 from 202 volunteers out of a total population of approximately 1900 in the Nathalia, Picola and Barmah area (Table 3).

TABLE 3 HI antibodies against arboviruses in 202 human volunteers - 1981

Age (years)	No. of Subjects	No. with HI antibodies			
		RRV	% positive	MVE	% positive
0-10	17	0	0%	0	0%
11-20	42	2	4.8%	0	0%
21-30	37	0	0%	0	0%
31-40	45	5	11.2%	1	2.2%
41-50	35	8	22.8%	1	2.8%
⩾ 51	26	14	53.0%	5	23.0%
TOTAL	202	29	14.3%	7	3.5%

In addition, in February 1982 the 3rd Preventive Medicine Company, Australian Army Reserve, conducted an exercise in the Barmah area in which 116 human sera and 594 sera from a variety of animal species were collected (Table 4).

TABLE 4 HI antibodies against arboviruses in humans and animals, Barmah 1982

Species	No. sera	No. with HI antibody					
		Alphavirus activity	RRV only	Sindbis only	Flavivirus activity	MVE only	Kunjin only
Man	116	63	34	7	32	6	9
Dog	159	59	16	18	33	3	8
Horse	114	42	8	13	15	0	6
Cattle	160	40	25	9	15	2	13
Pig	43	9	4	1	2	0	1
Bird	112	60	28	11	4	0	3
Rabbit	6	0	0	0	0	0	0

Following reports of neurological disorders in horses in the Mildura area in January 1982, blood specimens were collected throughout the Murray Valley with several horses being retested two weeks later. Ninety-five sera were tested for the presence of HI antibody against Sindbis and RRV antigens, with positive sera retested by the plaque inhibition/plaque reduction test. Thirty-seven horses had HI antibody against alphavirus antigen. Five paired sera exhibited rising antibody titres against RRV antigen indicating recent infection, seven single sera had high RRV antibody levels, and eight single sera had HI antibody against Sindbis virus.

The prospective 1982-83 arbovirus surveillance program commenced on 22 November 1982 following the establishment and testing of ten seronegative chicken flocks located in the same areas as in the previous year.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD - 11/11/82 - 24/11/82 BULLETIN NUMBER . 82/24
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	16				1	1	4	1	23
0101 ADENOVIRUS TYPE 1	1	1		1		2		1	6
0102 ADENOVIRUS TYPE 2	3		1	2		8			14
0103 ADENOVIRUS TYPE 3		1							1
0104 ADENOVIRUS TYPE 4						1			1
0105 ADENOVIRUS TYPE 5	1					1			2
0106 ADENOVIRUS TYPE 6						2			2
0108 ADENOVIRUS TYPE 8								1	1
0111 ADENOVIRUS TYPE 11								1	1
0119 ADENOVIRUS TYPE 19	1		1	3				17	22
0199 ADENOVIRUS TYPING PENDING			2		5	7			14
0201 INFLUENZA A VIRUS	12		1				7	4	24
0202 INFLUENZA A VIRUS SUBTYPE H3N2					2	3	1		6
0203 INFLUENZA B VIRUS	10		3			1	4	2	20
0301 PARAINFLUENZA VIRUS TYPE 1		1							1
0302 PARAINFLUENZA VIRUS TYPE 2								1	1
0303 PARAINFLUENZA VIRUS TYPE 3	2			2	16	7	3	1	31
0399 PARAINFLUENZA VIRUS TYPING PENDING						4			4
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)		1		1	1	1	2	1	7
0500 RHINOVIRUS (ALL TYPES)	3			4	9	1	5		22
0600 MYCOPLASMA PNEUMONIAE	69	2	1	3	2	3	11	12	103
0700 ORNITHOSIS-PSITTACOSIS	1			3					4
0800 COXSACKIEVIRUSES GROUP A - NOT TYPED								1	1
0809 COXSACKIEVIRUS A9	1								1
0903 COXSACKIEVIRUS B3			1			1	1		3
0904 COXSACKIEVIRUS B4		1							1
1002 ECHOVIRUS TYPE 2	1								1
1006 ECHOVIRUS TYPE 6	1		1						2
1011 ECHOVIRUS TYPE 11	2							9	11
1018 ECHOVIRUS TYPE 18				3					3
1022 ECHOVIRUS TYPE 22				1					1
1027 ECHOVIRUS TYPE 27								1	1
1030 ECHOVIRUS TYPE 30	1								1
1101 POLIOVIRUS TYPE 1								1	1
1102 POLIOVIRUS TYPE 2						1			1
1104 POLIOVIRUS-VACCINAL STRAIN			3						3
1200 MUMPS VIRUS	16	4	2	2	1	1		2	28
1300 HERPES VIRUS GROUP-NOT TYPED	46		2	3		10		1	62
1301 HERPES SIMPLEX VIRUS NOT-TYPED	2			3				52	57
1302 EPSTEIN-BARR VIRUS (EB VIRUS)	15								15
1303 VARICELLA-ZOSTER VIRUS	5		1	3		2	1		12
1306 HERPES SIMPLEX TYPE 1	6		7	17			18		48
1307 HERPES SIMPLEX TYPE 2	88		19	50			51		208
1399 HERPES VIRUS TYPING PENDING			8		1	26			35
1401 COXIELLA BURNETI	6			1		1	6		14
1502 PICORNA VIRUS-NOT TYPED	1							9	10
1521 MEASLES VIRUS	9	2		6	2		2		21
1522 RUBELLA VIRUS	7		4	4	1	2	19	5	42
1532 HEPATITIS B ANTIGEN	11		3	20		14	8	10	66
1535 HEPATITIS A ANTIBODY	1		3	16		5	6	10	41
1541 CHLAMYDIA A - C TRACHOMATIS	12		1					38	51
1556 CMV - CYTOMEGALOVIRUS	12		1	21		4	4	6	48
1563 CORONAVIRUS				3					3
1564 ROTAVIRUS		2	3	3	2	2	3		15
1599 ENTEROVIRUS TYPING PENDING		3	4		8		1		16
ROSS RIVER VIRUS								1	1
SMALL VIRUS (LIKE) PARTICLE				1					1
Total	362	18	72	176	51	111	157	188	1,135

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 11/11/82 to 24/11/82 .... 82/24

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
0101 ADENOVIRUS TYPE 1.....		3					2				
0102 ADENOVIRUS TYPE 2.....		8					4				
0103 ADENOVIRUS TYPE 3.....		1									
0105 ADENOVIRUS TYPE 5.....	1	1									
0106 ADENOVIRUS TYPE 6.....		1					1				
0111 ADENOVIRUS TYPE 11.....										1	
0119 ADENOVIRUS TYPE 19.....											1
0201 INFLUENZA A VIRUS.....	2	18	1						1		
0202 INFLUENZA A VIRUS SUBTYPE H3N2		5									
0203 INFLUENZA B VIRUS.....	1	9				1					3
0301 PARAINFLUENZA VIRUS TYPE 1....		1									
0302 PARAINFLUENZA VIRUS TYPE 2....											1
0303 PARAINFLUENZA VIRUS TYPE 3....	2	29									
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....		7									
0500 RHINOVIRUS (ALL TYPES).....		19					1				1
0600 MYCOPLASMA PNEUMONIAE.....	8	84	1			1	1	1	2		
0700 ORNITHOSIS-PSITTACOSIS.....		3									
0903 COXSACKIEVIRUS B3.....		1					2				
0904 COXSACKIEVIRUS B4.....		1									
1006 ECHOVIRUS TYPE 6.....				2							
1011 ECHOVIRUS TYPE 11.....	1	2		4					1		1
1018 ECHOVIRUS TYPE 18.....				2							1
1022 ECHOVIRUS TYPE 22.....		1									
1027 ECHOVIRUS TYPE 27.....	1										
1030 ECHOVIRUS TYPE 30.....				1							
1101 POLIOVIRUS TYPE 1.....	1										
1102 POLIOVIRUS TYPE 2.....							1				
1104 POLIOVIRUS-VACCINAL STRAIN....							3				
1200 MUMPS VIRUS.....	1		2	4							2
1301 HERPES SIMPLEX VIRUS NOT-TYPED	4	1									31
1302 EPSTEIN-BARR VIRUS (EB VIRUS).		1						3			1
1303 VARICELLA-ZOSTER VIRUS.....		1	1		1						9
1306 HERPES SIMPLEX TYPE 1.....	1	4						1			21
1307 HERPES SIMPLEX TYPE 2.....	2										14
1401 COXIELLA BURNETI.....	3	1									
1502 PICORNA VIRUS-NOT TYPED.....		1									3
1521 MEASLES VIRUS.....		3									19
1522 RUBELLA VIRUS.....	5	1									31
1532 HEPATITIS B ANTIGEN.....	14						1	42			
1535 HEPATITIS A ANTIBODY.....	3							34			
1556 CMV - CYTOMEGALOVIRUS.....	13	7			2	1		2		8	2
1563 CORONAVIRUS.....		2					1				
1564 ROTAVIRUS.....							15				
9992 ROSS RIVER VIRUS.....											1
Total.....	63	216	5	13	3	3	32	83	4	9	142

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 11/11/82 to 24/11/82 ... 82/24

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
0102 ADENOVIRUS TYPE 2.....							1	1		
0104 ADENOVIRUS TYPE 4.....	1									
0108 ADENOVIRUS TYPE 8.....	1									
0119 ADENOVIRUS TYPE 19.....	6	17								
0201 INFLUENZA A VIRUS.....							3	4		
0202 INFLUENZA A VIRUS SUBTYPE H3N2							1			
0203 INFLUENZA B VIRUS.....							3	3	1	
0302 PARAINFLUENZA VIRUS TYPE 2....					1					
0500 RHINOVIRUS (ALL TYPES).....								1		
0600 MYCOPLASMA PNEUMONIAE.....				2			9	4		
0700 ORNITHOSIS-PSITTACOSIS.....								1		
0809 COXSACKIEVIRUS A9.....							1	1		
1002 ECHOVIRUS TYPE 2.....							1			
1011 ECHOVIRUS TYPE 11.....								4		
1200 MUMPS VIRUS.....			10	12			2		2	
1301 HERPES SIMPLEX VIRUS NOT-TYPED		26								
1302 EPSTEIN-BARR VIRUS (EB VIRUS).			6				4		2	
1306 HERPES SIMPLEX TYPE 1.....	1	17				1		3	1	
1307 HERPES SIMPLEX TYPE 2.....		193								
1401 COXIELLA BURNETI.....							5	6		
1502 PICORNA VIRUS-NOT TYPED.....								1		
1521 MEASLES VIRUS.....				3			1	2		
1522 RUBELLA VIRUS.....					1	1	3	1	5	
1532 HEPATITIS B ANTIGEN.....								1	8	
1535 HEPATITIS A ANTIBODY.....									4	
1541 CHLAMYDIA A - C.TRACHOMATIS...	2	49								
1556 CMV - CYTOMEGALOVIRUS.....		4		2		6	3	2	4	
1563 CORONAVIRUS.....								1		
9992 ROSS RIVER VIRUS.....								1		
Total.....	11	306	16	19	2	8	37	37	27	1