AUSTRALIA

Communicable Diseases Intelligence

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Contents:

OUTBREAKS OF ARBOVIRUS INFECTIONS - PACIFIC ISLANDS

Recent issues of this bulletin (CDI 80/4 and 80/5) quoted reports of Ross River virus infections in Samoa last year and dengue, also in Samoa, this year.

Reports have now been received from the WHO Office in Fiji of recent outbreaks of:

(i) Ross River virus infections in Raratonga (Cook Islands) - confirmed in Honolulu in 4 out of 15 paired sera; and

(ii) dengue in Niue, a small island east of Tonga and South of Samoa. Approximately 600 cases have been reported with three deaths following haemorrhagic manifestations. Aedes aegypti, the usual vector of dengue, was first reported in Niue in 1972.

Travellers to these and to neighbouring islands should be advised to take strict precautions against mosquito bites.

CDI VIRUS REPORTING SCHEME

Total reports this period - 588, the smallest number received in one period for over a year.

General trends as indicated by the figures received include a decrease in mumps isolations (8 reports, compared with 23 and 48 the previous two periods), and eye infections (6 reports as opposed to 16 and 28 previously). Respiratory infections remain comparatively infrequent, the most commonly reported causative organism being para-influenza type 2.

Other reports of interest:

- Ross River virus - 30 reports, 26 of which were from Queensland (all local residents), two were from Darwin but reported by Western Australia, and the remaining two from South Australia, indicating a decrease from previous weeks.
- Hepatitis A - 19 out of a total of 24 reports were from Western Australia. Two of these were from Kalgoorlie. Previous Western Australian figures this year have ranged between one and six per period.
- Individual case reports included a Coxsackie A16 isolation from a case of "hand, foot and mouth" disease, and pseudo cow-pox from a milker's node.

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

Figures given may be subject to revision.

NOTIFIABLE DISEASE REPORTING

(The opinions expressed in this comment are those of the Editor - not necessarily those of the Department of Health.)

The final two pages of tables in this issue contain the current figures for diseases notified by States and Territories for the calendar year 1979. Previous issues of this bulletin (CDI 79/1 and 78/19) have commented on the fallibility of such statistics. The 1979 figures proved no exception. Although some of the rarely occurring and thus interesting diseases such as poliomyelitis, diptheria, anthrax and cholera might be reported accurately, this is certainly not the case with others or with the majority of the more common infections. These, by virtue of their high prevalence, are likely to be a larger drain on the national resources than the rare diseases, and are therefore deserving of far more attention than they currently receive.

Direct comparisons cannot be made between the notifiable disease system and other forms of information collection such as the CDI virus reporting scheme because of inherent differences in their structure and sources of data. They can however serve to illustrate inadequacies in our attempts to collect national data on communicable diseases. For example, approximately 4000 isolations of herpes simplex virus were reported in 1979 under the CDI scheme, of which over 50% came from genital sources, yet no notifications of genital herpes were received under the notifiable diseases scheme. This infection could be developing into one of the major public health problems in Australia, and if so, accurate epidemiological data could prove to be of immense value. Similarly, no cases of 'non-specific urethritis' were notified, although there were over 750 isolations of chlamydia from genital sources reported under the CDI scheme.

Trachoma is another example. Only one case was notified during 1979 and four in 1978. During these two years the National Trachoma and Eye Health Program was in progress, and was accompanied by wide press publicity on the high prevalence of trachoma amongst many groups of Aboriginals. More than 50% of the 60 000 persons screened were found to have trachoma.

One of the reasons for information from various sources not being incorporated into the national notifiable diseases statistics is that the latter are dependent on data collected under State or Territory legislation and provided voluntarily to the Federal Department of Health. Although the National Health and Medical Research Council (NH & MRC) recommends that certain diseases be "notifiable", the incorporation of such recommendations into appropriate State legislation may take time. Alternatively, a State might be of the opinion that the notification of a certain disease is not warranted in areas under its jurisdiction. In addition, States may add whatever other disease they wish. Such variations make any rational collection of nation-wide statistics difficult. Trachoma, for example, according to our information, is notifiable only in South Australia, the Northern Territory and Tasmania, while pertussis is notifiable only in Victoria. These variations do not facilitate the evaluation, on a national basis, of the respective control measures.

Even when a disease is legally notifiable within a State, it is frequently

under-reported. This is usually attributed to apathy or ignorance on the part of medical practitioners or clinical staff in hospitals. However public health administrators are not entirely devoid of blame. There have been several examples of outbreaks of epidemiological importance (e.g. Legionnaires' disease, Australian encephalitis) which have been widely reported in the press, confirmed by laboratory investigations and discussed in detail by phone, yet never included in the notifiable disease figures. It is tempting but impossible for the Federal Department of Health to modify official State figures, even if there is no doubt about the authenticity of the information and the proposed amendments are likely to result in more accurate statistics. Such action should therefore be undertaken at State level if it is considered there is any justification for the continued collection of notifiable disease figures.

If not, and assuming some form of data is mandatory (even if only for international reporting), what should take its place?

The CDI laboratory reporting scheme is limited basically to viruses from some laboratories. Other currently available alternatives comprise the national "mortality", and in some States "hospital in-patient morbidity" data collected by the Australian Bureau of Statistics. In even fewer States, hospital out-patient data collection is being developed, but it will be several years before these become nation-wide. These alternatives are obviously very limited and more likely to be of historical rather than current practical value by the time the figures for any year become available.

Reporting by laboratories and some special clinics appears to be the most reliable and consistent source of data on communicable diseases, and it is notable that laboratory confirmation of diagnosis is required for approximately 75% of the notifiable diseases on the NH & MRC list. A more reliable scheme based on laboratory reporting might be developed, although this would not account for the remaining 25% of diseases.

One possible solution for the latter would involve a careful reassessment of the justification for, and practicability of, the continued notification of each of these diseases. Appropriate sentinel laboratories or clinical centres would then have to be chosen to provide consistent and reliable data to indicate trends in the community.

This is not a problem which is likely to be solved immediately. However, it should not prove insurmountable as other countries appear to have succeeded in developing far more effective communicable disease reporting systems. With the changing pattern of communicable diseases in the community, current data is needed for both epidemiological monitoring and evaluation of preventive or control programs. In addition to these there is an increasing public demand for evaluation and justification of expenses incurred on health services. An improved communicable disease data collection system in this country therefore warrants a far higher priority than it is generally accorded, but its successful implementation will depend entirely on a vigorous and co-ordinated approach by all persons, institutions and authorities concerned.

INFLUENZA VIRUS ISOLATIONS - FAIRFIELD HOSPITAL

(Contributed by Kennett M., Donaldson, A., White J. and Williamson, G. of Fairfield Hospital, Victoria.)

Between January and August 1979, 31 isolates of Influenza A were obtained, and all resembled influenza A/Brazil/11/78 (H1N1). Five isolates were obtained from Fairfield Hospital staff, three from children at a reception centre and the remainder from patients admitted to the hospital. In November 1979 a strain similar to influenza A/Texas/1/77 (H3N2) was isolated from a two year old Vietnamese refugee who had entered Australia from Malaysia six days previously. He had had a mild upper respiratory tract infection for nine days.

The results for the year are summarised in Table I.

TABLE I

Monthly influenza isolations and serological diagnoses - 1979

	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Isolations:												
A/Brazil/11/78 like				4	18	6	2	1				
A/Texas/1/77 like											1	
Serology (Influenza A)	1			2	14	11	6	7		1		

The age distribution of patients from whom influenza A (H1N1) was isolated in 1978 and 1979 is shown in Table II.

TABLE II

Age distribution - 1978 and 1979

YEAR	STRAIN	AGE (YEARS)							TOTAL
		0-4	5-9	10-14	15-19	20-24	25-29	≥30	
1978	A/USSR/90/77		4	2	20	4			30
1979	A/Brazil/11/78		1	7	7	6	8	1	31

HI antibody to various influenza antigens were determined on sera collected from the Red Cross Blood Transfusion Service in December 1978 and 1979. The antigens used were:

Influenza A/Vic/131/78 which was similar to A/USSR/90/77 (H1N1),
Influenza A/Vic/105/77 which was similar to A/Texas/1/77 (H3N2), and
Influenza B/Hong Kong/5/72

The results are tabulated in Table III.

TABLE III

H1 ANTIBODY LEVELS AGAINST INFLUENZA ANTIGEN

SERA FROM MELBOURNE BLOOD BANK - DECEMBER 1978 AND 1979

ANTIGEN	DATE	AGE (YEARS)	TOTAL NO. TESTED	H1 ANTIBODY TITRE								% TITRE	GMT*
				<10	10	20	40	80	160	320	≥640	≥40	
H1N1	1978	18-60	97	18	20	26	19	10	3	1		34	19.4
A/Vic/131/78		18-24	32	11	7	9	3	2				16	12.4
= A/USSR/90/77	1979	18-58	100	11	12	23	26	20	8	1		55	31.2
		18-24	22	5	3	4	4	5	1			45	22.7
H3N2	1978	18-60	99	94	1	3	1					1	5.4
A/Vic/105/77	1979	18-58	100	92	6	1	1					1	5.4
= A/Texas/1/77													
B	1978	18-60	99	50	25	10	4	4	4	1	1	14	10.5
B/Hong Kong/5/72	1979	18-58	98	57	18	5	6	6	2	1	3	20	10.7

* Geometric Mean Titre.

ANTHRAX IN VICTORIA

A case of anthrax infection in a 44 year old man has been reported by Fairfield Hospital, Melbourne. He worked at a knackery in Sheparton, and was admitted on February 20 with a haemorrhagic, vesiculating lesion on his left index finger of two days duration. Gram-positive bacilli were seen in a direct smear of the lesion and subsequently the characteristic colonies of B. anthracis were obtained on culture. The organism was sent to the Veterinary Research Institute where the culture findings were confirmed by guinea-pig inoculation. The patient was treated with parenteral penicillin; initially the lesion progressed and oedema extended on to the hand, but then gradual resolution occurred. He is now recovering and a decision will be made soon on whether plastic surgery will be necessary to aid healing. The source of this man's infection was an abrasion which was contaminated with material from a cow which died from anthrax.

At present anthrax occurs only in New South Wales and Victoria. It has not been seen in South Australia since 1914, and in Tasmania the last animal case was reported in 1933. Queensland has apparently been free for over 70 years and the disease has never been recognised in Western Australia or the Northern Territory(1).

The last notification of human cases received from Victoria was in 1975, when two cases were notified. Since then, New South Wales has notified

one case in each of the years 1977 and 1979. Outbreaks in animals have occurred more frequently however, usually during the summer months. The Bureau of Animal Health in Canberra reports that between November 1979 and February 1980, 11 properties in New South Wales and two in Victoria were affected, with the loss of 884 animals which either died or were destroyed. There were no cases during the previous six cooler months.

Reference:

(1) Seddon H R (Ed) Diseases of domestic animals in Australia. 2nd edition. Commonwealth Dept. of Health 1965 Pt.5:1:12-26

β- LACTAMASE PRODUCING N. GONORRHOEAE

A further 17 isolations were reported during January and February:

South Australia - 9 males and 5 females. Probable sources of infection were Bangkok (1); Philippines (1); U.S.A. (1 and her contact locally); local (8) probably Sydney (1) and unknown (1).

Queensland - 1 male (Philippines) and Victoria - 1 male, 1 female; sources unknown.

These bring the total number of reported cases diagnosed in 1980 to 18.

The clinical histories of the two Victorian cases have been provided by M. McDonald and N. Sonenberg of the Royal Melbourne Hospital. They illustrate the difficulties which sometime occur in the diagnosis and tracing of the sources of these infections.

A 34 year old Italian-born housewife was admitted to hospital in late January with lower abdominal pain and fever. Appendicectomy was performed and the pathology of the appendix was reported as normal.

Five weeks later she again presented with the same symptoms. Suprapubic rebound tenderness was found and vaginal examination revealed tenderness (? and a mass) in the right fornix. A white vaginal discharge was noted. She was given tetracycline for 3 days. Cultures of swabs from the cervix grew a β-lactamase producing gonococcus. Subsequent throat, urethral and rectal cultures were negative. Ultrasonography suggested a right tubo-ovarian abscess. She was taken to theatre but no abscess was found - only mild inflammation of the fallopian tubes. Her post operative recovery was uneventful and she continued to deny any extramarital sexual contact.

In early January the patient's husband had attended his local medical practitioner with symptoms of urethritis. He was treated with procaine penicillin (0.5 megaunits i.m.) for 5 days. He returned 5 weeks later aggressive and still symptomatic. A urethral swab was taken and he was referred to the Venereal Diseases Clinic. Swabs from the urethra were positive and cultures grew β-lactamase producing gonococcus.

Swabs taken from the woman accompanying him to the clinic were negative. He insisted that his only recent sexual contact was with his present companion and that his wife had been in Italy for the past 8 months! (His wife was in hospital recovering from the first operation at that time). His symptoms of urethritis responded to spectinomycin 2G i.m.

Further history taken from all parties has failed to reveal the source of the infection.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD - 6-3-80 . 19-3-80 BULLETIN NUMBER 80.6 (1)

VIRAL IDENTIFICATIONS FROM CONTRIBUTING LABORATORIES

VIRUS OR VIRAL ANTIGEN	ICPMR (NSW) / MVH (ACT)	RAHC (NSW)	PHH/ POW (NSW)	FAIR-FIELD (VIC)	RCH (VIC)	IMVS (SA)	STATE LAB (QLD)	STATE LAB (WA)	Total
0100 ADENOVIRUS NOT TYPED	3		2	3	2	1	7		18
0101 ADENOVIRUS TYPE 1						1			1
0102 ADENOVIRUS TYPE 2						6			6
0103 ADENOVIRUS TYPE 3				1				1	2
0105 ADENOVIRUS TYPE 5				2		1			3
0107 ADENOVIRUS TYPE 7	1			1		1			3
0114 ADENOVIRUS TYPE 14						1			1
0115 ADENOVIRUS TYPE 15		1							1
0119 ADENOVIRUS TYPE 19						1			1
0199 ADENOVIRUS TYPING PENDING		1	1		1	1			4
0201 INFLUENZA A VIRUS			1						1
0203 INFLUENZA B VIRUS							2		2
0204 INFLUENZA C VIRUS							1		1
0302 PARAINFLUENZA VIRUS TYPE 2				2	8	1	2		13
0303 PARAINFLUENZA VIRUS TYPE 3		2			1	1		1	5
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)					1	3			4
0500 RHINOVIRUS (ALL TYPES)	1			1	14		4		20
0600 MYCOPLASMA PNEUMONIAE			3	1		1	6	1	12
0700 ORNITHOSIS-PSITTACOSIS	1			4		2		1	8
0800 COXSACKIEVIRUSES GROUP A - NOT TYPED							1	1	2
0816 COXSACKIEVIRUS A16								1	1
0902 COXSACKIEVIRUS B2		2							2
1000 ECHOVIRUS NOT TYPED							6		6
1003 ECHOVIRUS TYPE 3			1						1
1011 ECHOVIRUS TYPE 11		1	3	1		2	11		18
1019 ECHOVIRUS TYPE 19								2	2
1022 ECHOVIRUS TYPE 22	1				2				3
1025 ECHOVIRUS TYPE 25							1		1
1030 ECHOVIRUS TYPE 30				2					2
1099 ECHOVIRUS TYPING PENDING			3						3
1101 POLIOVIRUS TYPE 1						1			1

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD - 6 - 3 - 80 - 19 - 3 - 80 **BULLETIN NUMBER** 80.6 (2)

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
1102 POLIOVIRUS TYPE 2								2	2
1103 POLIOVIRUS TYPE 3						1			1
1104 POLIOVIRUS-VACCINAL STRAIN	2		1						3
1200 MUMPS VIRUS			2	4			2		8
1300 HERPES VIRUS GROUP-NOT TYPED	1			1		3		2	7
1301 HERPES SIMPLEX VIRUS-NOT TYPED	8	1			1		16	37	63
1303 VARICELLA-ZOSTER VIRUS	1			1			2	3	7
1306 HERPES SIMPLEX TYPE 1	2		3	11		8			24
1307 HERPES SIMPLEX TYPE 2	33		3	12		6			54
1399 HERPES VIRUS TYPING PENDING			2			2			4
1401 COXIELLA BURNETI	11		1	2		2	13		29
1512 VACCINIA VIRUS			1						1
1515 CONTAGIOUS PUSTULAR DERMATITIS (ORF VIRUS)				1					1
1521 MEASLES VIRUS			2	1			3		6
1522 RUBELLA VIRUS	2			2		2	1	6	13
1530 HEPATITIS A VIRUS								19	19
1531 HEPATITIS B VIRUS				1					1
1532 HEPATITIS B ANTIGEN	5	2	5	19		17	4	7	59
1535 HEPATITIS A ANTIBODY						5			5
1541 CHLAMYDIA A - TRIC TYPE	8		3					37	48
1556 CMV - CYTOMEGALOVIRUS	3	1	5	15	1		7	5	37
1564 ROTAVIRUS	1		2	1	2	3			9
1599 ENTEROVIRUS TYPING PENDING					6	1			7
ROSS RIVER VIRUS						2	26	2	30
ARBOVIRUS				1					1
DENGUE							1		1
Total	84	11	44	90	39	76	116	128	588

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 6/3/80 to 19/3/80 ....(80/6)
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; 09 -Urinary; 06 -Skin/mucous.

(3)

VIRUS OR VIRAL ANTIGEN	No-ill or data	Respiratory	Encephalitis	Meningitis	Paralysis	CNS other unspec	GI	Hepatic	CVS	Urinary	Skin/ mucs memb
0100 ADENOVIRUS NOT TYPED	1	3				1	4				
0101 ADENOVIRUS TYPE 1			1								
0102 ADENOVIRUS TYPE 2		2					4				
0103 ADENOVIRUS TYPE 3		1									
0105 ADENOVIRUS TYPE 5		1		1			1				
0107 ADENOVIRUS TYPE 7							2				
0114 ADENOVIRUS TYPE 14							1				
0201 INFLUENZA A VIRUS		1									
0203 INFLUENZA B VIRUS		3									
0204 INFLUENZA C VIRUS											1
0302 PARAINFLUENZA VIRUS TYPE 2	2	10									1
0303 PARAINFLUENZA VIRUS TYPE 3		5	1								
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)		4									
0500 ADENOVIRUS (ALL TYPES)		6									
0600 MYCOPLASMA PNEUMONIAE	2	4		1							
0700 ORNITHOSIS-PSITTACOSIS		5									
0800 COXSACKIEVIRUSES GROUP A - NOT TYPED						1					
0816 COXSACKIEVIRUS A16											1
0902 COXSACKIEVIRUS B2		1				1					
1000 ECHOVIRUS NOT TYPED	2			2							
1003 ECHOVIRUS TYPE 3							1				
1011 ECHOVIRUS TYPE 11		2		9		1	5		1		
1019 ECHOVIRUS TYPE 19						2					
1022 ECHOVIRUS TYPE 22	2	1									
1025 ECHOVIRUS TYPE 25				1							
1030 ECHOVIRUS TYPE 30				2							

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 6/3/80 to 19/3/80 ....(80/6) (4)
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 -Drinary; 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	Drin-ary	Skin/ Mucs Memb
1101 POLIOVIRUS TYPE 1							1				
1102 POLIOVIRUS TYPE 2		1				1					
1103 POLIOVIRUS TYPE 3		1									
1104 POLIOVIRUS-VACCINAL STRAIN							3				
1200 MUMPS VIRUS		2		1							
1300 HERPES VIRUS GROUP-NOT TYPED											4
1301 HERPES SIMPLEX VIRUS-NOT TYPED	7	1		2			1		1		38
1303 VARICELLA-ZOSTER VIRUS	2										5
1306 HERPES SIMPLEX TYPE 1	2	1		1							15
1307 HERPES SIMPLEX TYPE 2											3
1401 COXIELLA BURNETI		3							1		
1512 VACCINIA VIRUS											1
1515 CONTAGIOUS PUSTULAR DERMATITIS (ORF VIRUS)											1
1521 MEASLES VIRUS			2	1							3
1522 RUBELLA VIRUS	2										8
1530 HEPATITIS A VIRUS	2							17			
1531 HEPATITIS B VIRUS								1			
1532 HEPATITIS B ANTIGEN	28							29			
1535 HEPATITIS A ANTIBODY								5			
1541 CHLAMYDIA A - PSIT TYPE	36										
1556 CMV - CYTOMEGALOVIRUS	6	2				1		2		8	1
1564 ROTAVIRUS	2						7				
ROSS RIVER VIRUS	1										8
ASTROVIRUS							1				
Total	97	60	4	21		8	31	54	3	8	90

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

PERIOD : 6/3/80 to 19/3/80 ... (80/6) (5)
Viral Identifications by Clinical Information Table 2.
Code 10 -Eye; 59 -Genital; 39 -Endo/sal gland;
38 -RES; 29 -Muscle/joint; 69 -Congenital; P8 -PUO;
G8 -Fever/malaise; 09 -Other; A1 -SIDS ...

VIRUS OR VIRAL ANTIGEN	Eye	Genital	Endo/sal gland	RES	Muscle/joint	Congenital	PUO	Fever/malaise	Other	SIDS
0100 ADENOVIRUS NOT TYPED	1		3					3	1	
0103 ADENOVIRUS TYPE 3	1									
0107 ADENOVIRUS TYPE 7								1		
0115 ADENOVIRUS TYPE 15	1									
0119 ADENOVIRUS TYPE 19	1									
0303 PARAINFLUENZA VIRUS TYPE 3							1			
0600 MYCOPLASMA PNEUMONIAE					2			5		
0700 ORNITHOSIS-PSITTACOSIS					1		3			
1000 ECHOVIRUS NOT TYPED								2		
1011 ECHOVIRUS TYPE 11								2	1	
1019 ECHOVIRUS TYPE 19								2		
1102 POLIOVIRUS TYPE 2								1		
1200 MUMPS VIRUS			5	1						
1301 HERPES SIMPLEX VIRUS-NOT TYPED	1	14								
1306 HERPES SIMPLEX TYPE 1		4		1				1		
1307 HERPES SIMPLEX TYPE 2		51								
1401 COXIELLA BURNETI							10	16		
1521 MEASLES VIRUS					1					
1522 RUBELLA VIRUS			2		2				1	
1532 HEPATITIS B ANTIGEN				1					1	
1541 CHLAMYDIA A - TRIC TYPE	1	11								
1556 CMV - CYTOMEGALOVIRUS			1	3		5		5	3	2
ROSS RIVER VIRUS					28			1		
DENGUE (TYPE 3)					1					
Total	6	80	11	6	35	5	14	39	7	2

NOTIFIABLE DISEASES - AUSTRALIA 1979

Disease	N.S.W.	VIC	QLD	S.A.	W.A.	TAS.	N.T.	A.C.T.	Total
Amoebiasis		3	1	4	5	1		3	17
Ankylostomiasis			15		1		160		176
Anthrax	1								1
Arbovirus infection		27	35		3				65
Brucellosis	17	9	3	28	1				58
Campylobacter infections									—
Chancroid	1		19						20
Cholera		1							1
Congenital rubella syndrome									—
Diphtheria									—
Donovanosis			67				12		79
Giardiasis									—
Genital herpes									—
Gonococcal ophthalmia neonatorum									—
Gonorrhoea	3656	2601	1695	1110	1203	191	911	280	11,647
Hepatitis A (infectious)	644	490	242	108	48	86	217	62	1,897
Hepatitis B (serum)	177	266	88	189	30	1	17	15	783
Hepatitis - unspecified		2			79			1	82
Hydatid disease	7	5	2	3		1		6	24
Lassa Fever									—
Legionnaires disease									—
Leprosy	5	9	9	6	12		18		59
Leptospirosis		36	12	15	1				64
Lymphogranuloma venereum		1						1	2
Malaria	72	68	132	31	35	1	9	18	366
Marburg Disease									—
Meningococcal infections		3	74	5	1			1	84
Non-specific urethritis									—
Ornithosis	2			7	1	1			11
Pertussis (whooping cough)		174							174
Plague									—
Poliomyelitis									—
Q. fever	51	124	324	67					566
Rabies									—

Disease	N.S.W.	VIC	QLD	S.A.	W.A.	TAS.	N.T.	A.C.T.	Total
Salmonella infections	284	128	115	465	451	28	294	19	1,784
Shigella infections		10	54	101	163		326	4	658
Smallpox									—
Syphilis	784	113	1097	355	230	2	578	6	3,165
Tetanus	3	6	5	1					15
Trachoma			1						1
Tuberculosis (all forms)	559	399	248	123	179	17	35	20	1,580
Typhoid fever	12	4	2		4	1			23
Typhus (all forms)			2		1				3
Vibrio parahaemolyticus infections									—
Yellow Fever									—
Yersinia enterocolitica infections									—