AUSTRALIA

Communicable Diseases Intelligence

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Contents:

VIRUS REPORTING SCHEME - A total of 891 reports were received this period. General trends as suggested by the reports include changes in the pattern of respiratory infections. Rhinovirus infections now appear to be the most prevalent, 35 reports received compared with 27, 32 and 20 for the previous three periods, whereas reports of respiratory syncytial virus and influenza A and B virus infections have declined. The number of reports for parainfluenza virus and Mycoplasma pneumoniae infections have remained constant.

Reports of interest include:

- An outbreak of gastroenteritis occurred at St Margaret's Hospital for Women, Sydney. Predominant symptoms were vomiting, loose stools and low grade fever, although some neonates presented with diarrhoea only. The Institute of Clinical Pathology and Medical Research detected rotavirus by electron microscopy in faecal specimens from five of six symptomatic babies. Four of 11 asymptomatic babies in the same ward were also shown to be excreting rotavirus.
- The State Health Laboratory, Perth, reported a suspected case of Kawasaki disease, or muco-cutaneous lymph node syndrome in a six year old girl. Poliovirus type 1 was isolated in HF32 fibroblasts from her nasal aspirate specimen.
- A case of dengue was confirmed by the State Health Laboratory, Brisbane, is a 32 year old female. She had recently been to Malaya with her husband, a member of the Armed Forces.
- The fifth 1980 isolation, but first from genital sources, of adenovirus type 11 was reported by the State Health Laboratory, Perth. The patient was a 22 year old male.
- Cocos Islands - Sera (141 specimens, some paired) from patients who had presented with a pharyngo-tonsillitis fever syndrome in September were tested for antibody to arbovirus infection. Culex fatigans and a member of the Aedes (Stegomyia) group are known to be on the islands, although an intensive mosquito survey has not been performed. All sera were negative for HI antibodies to alphaviruses, and although 12 sera had low levels of antibody to flaviviruses, no rises in titre were detected.

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NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL (NH&MRC) STATEMENTS

At a meeting in October 1980, the Council made the following statements pertaining to communicable diseases:

Smallpox vaccination

At its Eighty-Eighth Session in October 1979 the Council had noted the World Health Organisation announcement that smallpox was eradicated. It noted that despite the WHO pronouncement, and the fact that only a small number of countries still required smallpox immunisation as a quarantine measure, vaccination against this disease was still being performed extensively.

Smallpox vaccination carries a small but measurable risk of serious complications to both vaccinees and their contacts, and Council considered that there was consequently a greater risk associated with the administration of smallpox vaccine than of contracting the disease itself.

The Council drew the attention of medical practitioners to the fact that there is no evidence that smallpox vaccination has therapeutic value in the treatment of recurrent herpes simplex infection, warts, or any other disease.

The Council therefore warned practitioners against performing vaccination against smallpox as a routine or using it as a therapeutic procedure. Vaccination against smallpox was not justified except for personnel likely to be exposed to smallpox vaccine or vaccinia or other related orthopoxviruses.

Editorial Comment - Despite the recommendations, smallpox vaccine is still being used in Australia in large quantities. In the nine months to September 1980, a total of 95 774 doses were distributed by CSL compared with 184 842 doses in the same period in 1979 - a reduction of only 48.2% despite the global eradication of the disease. Smallpox vaccine will be deleted from the schedule of pharmaceutical benefits as from 1 April 1981.

Toxic Shock Syndrome

Toxic Shock Syndrome is characterised by an erythematous rash, high fever, vomiting, diarrhoea and myalgia, followed by hypotension and, in severe cases, shock. The condition can occur in men and women, but the vast majority of cases have been reported in young women during the menstrual period.

The Council considered recent reports from overseas linking this severe and sometimes fatal illness with the use of tampons. Staphylococcus aureus is believed to be a significant contributing factor.

The Council considered that although the reported overseas incidence of toxic shock syndrome (TSS) associated with tampon use was relatively low and that no cases had been reported to health authorities in Australia to date, nevertheless the severity of the illness and the case-fatality ratio

constituted a cause for concern.

The largest number of tampon related cases have been reported in the USA in association with a brand of tampon marketed under the name 'Rely'. The Council understood that this brand contained carboxy-methyl-cellulose to increase absorbency and is presented in a plastic sheath to aid insertion. Although it is believed such products are not marketed here, comprehensive sampling and analysis of locally available brands is under way in Australia.

The Council considered there were certain safety measures which Australian women could adopt, and it recommended that:

- Women who choose to use tampons could reduce the very small risk of suffering toxic shock syndrome by using them intermittently during each menstrual period. Tampons should be changed on average at least 4 or 5 times daily and preferably not used at night. A high standard of personal hygiene should accompany their use. They should not be handled excessively and should be inserted in a manner to avoid any damage to the vaginal wall.
- A woman using tampons who developed a fever during her menstrual period should remove the tampon and contact her doctor.
- Because of a significant recurrence rate, women who have sustained an episode of toxic shock syndrome should not use tampons again without first obtaining medical advice.

Editorial Comment - The CDI would be interested in receiving information on any cases of this newly recognized illness that have occurred in Australia. No reports have been received since the initial request in CDI 80/16.

Hepatitis A in Workers

The Council examined the advisability of the use of immunoglobulin for contacts of a case of hepatitis A in the workplace and considered that routine administration of immunoglobulin to such contacts was not generally necessary. However, the Council agreed that in certain circumstances the use of immunoglobulin might be warranted. A decision on this matter should be made by a medical practitioner or medical officer after the relevant facts of the particular situation had been ascertained.

Circumstances that might warrant the administration of immunoglobulin would include regular and close contact with the patient during the two weeks prior to the commencement of illness, as distinct from an occasional incident. Such contact may occur through consuming food or using food or drink utensils handled by the patient; sharing the same towel; or regular and constant handling of the same tools or equipment.

Head Lice

The Council noted the prevalence among schoolchildren of head lice and nits (pediculosis). It considered that exclusion of children from school until neither lice nor nits can be found on the scalp or hair would seriously disrupt school attendances without achieving the desired benefit. The Council also noted that more effective preparations for the control of this condition are now in use, and it recommended that affected children should not be excluded from school attendance if undergoing treatment for pediculosis.

Dengue Fever

The Council viewed with concern the spread of dengue and dengue haemorrhagic fever in the Pacific Islands neighbouring Australia. It noted the introduction of the vector mosquito Aedes aegypti and its spread to new areas within northern Australia and to other countries in the Pacific region.

The Council therefore recommended that Aedes aegypti surveillance be intensified in the potential receptive areas of Australia and in Norfolk Island, with appropriate control measures being implemented where necessary.

Rift Valley Fever

The Council noted that Rift Valley fever had increased significantly during the last three years. The condition, which presents as an acute febrile illness of cattle, sheep and man had until recently occurred only in central and southern Africa, but more recently in late 1977 and 1978, outbreaks in both man and animals had occurred in Egypt.

It also noted a reported case imported into Canada from Africa in 1979 in which ophthalmological complications had taken place. The possibility existed of persons returning to Australia with viraemia; in the acute stages the blood was highly infectious which presented considerable risks to personnel involved in handling it.

Council emphasised the need for early diagnosis of Rift Valley fever, the importance of continuing sero-epidemiological work in this field and for the establishment of adequate diagnostic facilities for both man and animals.

Editorial Comment - At present the laboratory diagnosis of suspected Rift Valley fever cases will be performed by Dr Ian Marshall in the high security laboratory of the Brucella Vaccine Testing Section, National Biological Standards Laboratory, Canberra.

Mumps Immunisation

The Council expressed concern at the number of children who had reached puberty without having attained immunity from mumps by means of natural infection. It noted the efficacy of mumps vaccine in providing protection

for at least 8 or 9 years, and recommended that it be included in its routine immunisation schedule.

Editorial Comment - The incorporation of mumps immunisation into the Council's recommended immunisation schedule will be considered at the next meeting of the NH&MRC Communicable Diseases Committee in 1981.

CDI SEROLOGY SURVEYS

(Contributed by R. Whybin and P. Robertson, Prince of Wales Hospital, Sydney.)

Surveys of the diagnostic serology service provided by the laboratories participating in the CDI virus reporting scheme have been conducted regularly since 1978. Several other diagnostic laboratories have been included in some of the surveys.

The investigations have been organised and conducted by the Serology Department, Prince of Wales Hospital, Sydney, and comprise requests for specific antibody testing on coded serum samples. Short clinical histories are provided with the samples.

To date, five surveys have been completed:

- October 1978 - Comparison of CF antibody titres to adenovirus and cytomegalovirus in eight sera (reported in CDI 78/24).
- February 1979 - Comparison of CF antibody titres to mumps virus in three sera.
- October 1979 - Comparison of CF antibody titres to varicella-zoster, herpes simplex, measles and mumps virus in two sera.
- March 1980 - Comparison of CF antibody titres to varicella-zoster, herpes simplex, measles and mumps virus in four sera.
- July 1980 - Comparison of antibody titres to rubella virus in four sera.

The results of the March 1980 survey of 14 laboratories are illustrated in Tables 1 and 2. In the tables (-) indicates that the laboratory did not carry out a particular test.

TABLE 1 March 1980 survey:- Antibody titres to varicella-zoster and herpes simplex virus

Laboratory number	Varicella-Zoster CF Titres				Herpes Simplex CF Titres			
	Sera				Sera			
	A	B	C	D	A	B	C	D
1	-	-	-	-	-	-	-	-
2	<4	4	<4	<4	32	64	64	32
3	<4	4	<4	<4	16	32	16	8
4	16	-	<8	32	32	-	32	16
5	<8	<8	<8	8	8	16	16	16
6	<20	<20	<20	<20	40	80	40	20
7	<8	16	<8	<8	64	64	128	64
8	<4	<4	<4	<4	32	64	32	16
9	-	-	-	-	-	-	-	-
10	5	10	5	10	20	40	40	40
11	10	20	5	40	40	80	80	40
12	<10	-	<10	<10	40	-	40	40
13	<20	<20	<20	-	<20	<20	20	-
14	8	<8	8	<8	64	64	64	64
RANGE	<4-16	<4-20	<4-8	<4-40	8-64	16-80	16-128	8-64

TABLE 2 March 1980 survey:- Antibody titres to measles and mumps virus

Laboratory number	Measles CF Titres				Mumps CF Titres			
	Sera				Sera			
	A	B	C	D	A	B	C	D
1	16	32	<8	128	<8	<8	<8	<8
2	16	16	<4	128	4(<4)	4(<4)	<4(4)	<4(<4)
3	4	8	<4	16	<4	<4	<4	<4
4	8	-	<8	32	16(<8)	-	16(<8)	16(<8)
5	8	16	<8	32	<8	<8	<8	<8
6	<20	<20	<20	40	<20	<20	<20	<20
7	32	32	<8	128	<8	<8	<8	<8
8	-	-	-	-	<4	<4	<4	<4
9	-	-	-	-	-	-	-	-
10	10	10	5	40	5	5	5	5
11	10	20	10	20	10	10	20	10
12	-	-	-	-	<10	-	<10	<10
13	<20	<20	<20	-	-	-	-	-
14	32	32	16	128	16	16	32	16
RANGE	4-32	8-32	<4-16	16-128	<4-16	<4-16	<4-32	<4-16

Laboratories 2 and 4 reported mumps 'S' soluble antigen (the nucleo-protein core of the virus particle) as well as mumps 'V' viral antigen (found on the surface of the virus particle). The antibody titres to the 'S' antigen are given in brackets.

Interpretation of the results was difficult in the specimens with low antibody levels. For example, in specimen B titres against varicella-zoster of <20 were regarded as implying absence of antibody, while titres of 4, 10 and 16 were regarded as evidence of immunity to varicella.

The results of the July 1980 survey of antibody levels to rubella virus are given in Table 3. The four specimens were pooled serum samples collected from pregnant women attending an ante-natal clinic. The antibody titres assayed by the three techniques were equivalent, and agreement between the laboratories was reasonable.

Overall, the survey results indicated that individual laboratories were able to achieve reproducible results in the assessment of titres on duplicate serum samples (not shown). Although the titres reported for the same serum by different laboratories were spread over an up to four-fold range, when the participants were requested to interpret the antibody titres with respect to serological diagnosis (not shown), a high degree of uniformity was demonstrated. Each also detected rising titres or reported titres considered to be elevated in sera collected from patients with recent or current infections.

In both surveys shown, differences were observed in the titres and interpretations of the sera with low levels of antibody. Specimens with levels of antibody either low or undetectable tested in the survey laboratory gave titres of from 1:4 to less than 1:20 by others. This difference in minimum titres affected the interpretation of immune status, and the lack of agreement occurred both with complement fixation and haemagglutination inhibition tests. Since the establishment of immune status is a common request in diagnostic serology, further standardisation is required in this aspect of serological testing.

The results of these surveys emphasise the importance of the accepted practice of testing paired specimens of serum in parallel for seroconversion. The interpretation of single elevated titres can be reliable if a "normal range" for that test in that laboratory is individually taken into account.

Editorial Comment on Rubella Survey

The variations reported may not be of major importance in the diagnosis of recent infections, but laboratories are frequently requested to provide immune status reports for individuals at risk. Standardisation of results both within and between laboratories in this area is of paramount importance, especially in rubella antibody screening[1,2,3]. Such screening is usually performed on a single serum sample, and the interpretation of the antibody titres then provides the basis for advice, management and possible immunisation of the patient. The four-fold variations in antibody titre reported for the same serum sample do not facilitate interpretation.

Haemagglutination inhibition (HAI) is the most frequently used laboratory test, but a low HAI titre may be the result of persisting non-specific inhibitors, rather than true antibody, despite pre-treatment. Radial

TABLE 3 July 1980 survey:- Antibody titres to rubella virus

Participant	Method	Antigen	A	B	C	D
1	H.A.I.	C.S.L. (Haemagglutinin)	16	16	64	256
2	H.A.I.	Calbiochem-Behring	10	20	40	320
3	H.A.I.	Flow Labs	10	10	48	320
4	(H.A.I.	Flow Labs	10	10	40	160
	(FIAX		7	13	28	176
5	-	-	-	-	-	-
6a	H.A.I.	Calbiochem-Behring	20	20	-	640
6b	H.A.I.	Flow Labs	<10	20	80	160
6c	H.A.I.	Calbiochem-Behring	16	16	32	128
6d	H.A.I.	Flow Labs	10	20	80	640
7	S.R.H.T.	C.S.L. (Haemagglutinin)	8	13	53	318
8	H.A.I.	Flow Labs	10	20	80	640
9	H.A.I.	Flow Labs	<10	<10	20	160
10	-	-	-	-	-	-
11	H.A.I.	Calbiochem-Behring	20	20	80	640
RANGE			7-20	10-20	20-80	160-640

H.A.I. = Haemagglutination inhibition assay
F.I.A.X. = Fluorescent immunoassay
S.R.H.T. = Single radial haemolysis test
- = Results not received

haemolysis (RH) gels have been developed for rubella antibody screening[4], and comparison with HAI and immunofluorescence tests suggest that as well as being simpler, the RH test is more specific and sensitive. A possible disadvantage however, is that it does not detect IgM or IgA antibodies, and widely spaced collections of sera are needed to determine seroconversion. Other assays such as immunofluorescence and ELISA have yet to be evaluated, and results are frequently converted to HAI units. This diversity of diagnostic techniques again adds to the variation on antibody assessment.

For purposes of immunisation, antibody titres of <1:8 are generally regarded as unsatisfactory, and 1:40 as acceptable. However, reinfection following vaccination or naturally acquired infection is well documented[5,6]. Some persons with low levels of HAI antibodies resulting from naturally acquired infection demonstrate a good booster response upon vaccine challenge, while others who are solidly immune do not respond to challenge[7]. Rubella infections are acquired through the nasopharyngeal mucosa, and consequently rubella specific secretory IgA antibody is induced. However, again it is found that no level of nasopharyngeal nor serum antibody is associated with protection from reinfection[7]. It is thought that local T-cell activity is required. The production of neutralising (NT) antibodies as a guideline for immunity[8] is also being debated, since the cell line used for the assay system may influence the results[9].

An additional problem exists in that a small but definite number of persons receiving live rubella vaccine fail to show serological conversion to the immune state, and various trials report failure rates of 2-5% depending chiefly on the type of vaccine used. Approximately up to one-third of the vaccinees may respond with a low HAI titre[10].

Because of the variation in the assessment of rubella immunity, answers to the following questions remain elusive:

- What antibody level must a woman have to be considered immune?
- Would this level in the mother guarantee protection of the foetus against congenital rubella syndrome?
- When should immunisation be "strongly recommended" as opposed to merely "advisable"?

Standardisation of antibody testing would take us nearer to the answers. An antibody titre, or at least a range of antibody titres, could then be adopted throughout Australia as an indication of immunity or susceptibility needing immunisation.

References

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2. J.Med.Virol. (1980) 5:329
3. Abst.Gynecol. (1980) 56:127
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5. NEJM (1970) 283:771
6. J.Paed. (1972) 81:460
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8. Scand.J.Inf.Dis. (1975) 7:169
9. J.Inf.Dis. (1978) 138:877
10. Am.Intern.Med. (1975) 83:412

β-LACTAMASE PRODUCING N.GONORRHOEAE

Ten further isolations have been reported for October and brings the 1980 total to 121, compared with 36 and 42 reports received for the whole of 1979 and 1978 respectively.

Sex	Age	State	Origin on contact
M	22	South Australia	Local
M	same person above	South Australia	Reinfection, local
F	23	South Australia	Local
M	22	South Australia	Local
F	20	South Australia	Local
F	same person above	South Australia	Reinfection, local
F	19	South Australia	Local
F	20	South Australia	Local
M	21	South Australia	Philippines
M	26	South Australia	Philippines

The first eight cases were all involved in one "chain of infection" - the origin of this PPNG is unknown at this stage.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

1

REPORTING PERIOD - 13 - 11 - 80 — 26 - 11 - 80 BULLETIN NUMBER . 80/24.

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	5		1		1	2	3	2	14
0101 ADENOVIRUS TYPE 1				1	3	1			5
0102 ADENOVIRUS TYPE 2	3			2	5	3		1	14
0103 ADENOVIRUS TYPE 3								2	2
0105 ADENOVIRUS TYPE 5	1					2			3
0107 ADENOVIRUS TYPE 7					3				3
0111 ADENOVIRUS TYPE 11								1	1
0119 ADENOVIRUS TYPE 19								7	7
0131 ADENOVIRUS TYPE 31					1				1
0199 ADENOVIRUS TYPING PENDING		1	2		2	3			8
0201 INFLUENZA A VIRUS	6			7		5	2	2	22
0202 INFLUENZA A VIRUS SUBTYPE H3N2	1			2	2				5
0203 INFLUENZA B VIRUS	5	1		4	1	6	2		19
0301 PARAINFLUENZA VIRUS TYPE 1							2		2
0302 PARAINFLUENZA VIRUS TYPE 2					1	1			2
0303 PARAINFLUENZA VIRUS TYPE 3		1		2	11	4	1	1	20
0399 PARAINFLUENZA VIRUS TYPING PENDING						1			1
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	1				2	3		3	9
0500 RHINOVIRUS (ALL TYPES)	5			4	15	8	1	2	35
0600 MYCOPLASMA PNEUMONIAE	7		4			1		1	13
0700 ORNITHOSIS-PSITTACOSIS	3		1	6				1	11
0800 COXSACKIEVIRUSES GROUP A - NOT TYPED							2		2
0809 COXSACKIEVIRUS A9					5	1	2	1	9
0816 COXSACKIEVIRUS A16	1						1		2
0902 COXSACKIEVIRUS B2						1		3	4
1006 ECHOVIRUS TYPE 6		1							1
1007 ECHOVIRUS TYPE 7								1	1
1009 ECHOVIRUS TYPE 9	1		1	3	1		2		8
1011 ECHOVIRUS TYPE 11	1								1
1021 ECHOVIRUS TYPE 21								1	1
1022 ECHOVIRUS TYPE 22			2						2

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE 2

REPORTING PERIOD - 13-11-80 — 26-11-80 BULLETIN NUMBER . 80/24

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
1030 ECHOVIRUS TYPE 30	2			6					8
1099 ECHOVIRUS TYPING PENDING			1						1
1101 POLIOVIRUS TYPE 1								2	2
1102 POLIOVIRUS TYPE 2						2	1		3
1103 POLIOVIRUS TYPE 3							1		1
1104 POLIOVIRUS-VACCINAL STRAIN			3						3
1200 MUMPS VIRUS	3			4	1	2	1	2	13
1300 HERPES VIRUS GROUP-NOT TYPED	10			8		8			26
1301 HERPES SIMPLEX VIRUS NOT-TYPED	12	2		3	1			41	59
1303 VARICELLA-ZOSTER VIRUS	2		2	1		2	2		9
1306 HERPES SIMPLEX TYPE 1	7		7	16		16	6		52
1307 HERPES SIMPLEX TYPE 2	50		4	31		24	14		123
1399 HERPES VIRUS TYPING PENDING			2		2	2			6
1401 COXIELLA BURNETI	15			4		4	14	1	38
1515 CONTAGIOUS PUSTULAR DERMATITIS (ORF VIRUS)						1		1	2
1521 MEASLES VIRUS	3	2	2	1				4	12
1522 RUBELLA VIRUS	8		2	4			3	4	21
1532 HEPATITIS B ANTIGEN	4		7	25	1	11	3	5	56
1535 HEPATITIS A ANTIBODY			1	1		2		2	6
1541 CHLAMYDIA A - TRIC TYPE	24		7					109	140
1555 PAPOVAVIRUS GROUP (PAPILLOMA-HUMAN WART)	1								1
1556 CMV - CYTOMEGALOVIRUS	6		5	14	2	3	1	7	38
1563 CORONAVIRUS	1								1
1564 ROTAVIRUS	14		3	3		2		3	25
1599 ENTEROVIRUS TYPING PENDING				1	5	1			7
POXVIRUS GROUP NOT TYPED				1					1
ROSS RIVER VIRUS							8		8
DENGUE							1		1
Total	202	8	57	154	65	122	73	210	891

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE 3

PERIOD : 13/11/80 to 26/11/80 .... 80/24

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
0100 ADENOVIRUS NOT TYPED.....		2					4				
0101 ADENOVIRUS TYPE 1.....		2					2				
0102 ADENOVIRUS TYPE 2.....		9					2				1
0103 ADENOVIRUS TYPE 3.....	1	1									
0105 ADENOVIRUS TYPE 5.....		1					2				
0107 ADENOVIRUS TYPE 7.....		1									
0131 ADENOVIRUS TYPE 31.....				1							
0201 INFLUENZA A VIRUS.....	2	15						1			1
0202 INFLUENZA A VIRUS SUBTYPE H3N2		2		1							1
0203 INFLUENZA B VIRUS.....		12									
0301 PARAINFLUENZA VIRUS TYPE 1....											1
0302 PARAINFLUENZA VIRUS TYPE 2....		1		1							
0303 PARAINFLUENZA VIRUS TYPE 3....		19									1
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....	1	6							1		
0500 RHINOVIRUS (ALL TYPES).....	1	31					1				
0600 MYCOPLASMA PNEUMONIAE.....	2	5									
0700 ORNITHOSIS-PSITTACOSIS.....	1	9									
0800 COXSACKIEVIRUSES GROUP A - NOT TYPED.....	1										
0809 COXSACKIEVIRUS A9.....	1	3		1			1	1			
0816 COXSACKIEVIRUS A16.....											2
0902 COXSACKIEVIRUS B2.....	1						1				1
1006 ECHOVIRUS TYPE 6.....				1							
1007 ECHOVIRUS TYPE 7.....	1										
1009 ECHOVIRUS TYPE 9.....	1	1		1			2				1
1022 ECHOVIRUS TYPE 22.....							1	1			
1030 ECHOVIRUS TYPE 30.....				8							

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE 4

PERIOD : 13/11/80 to 26/11/80 .... 80/24

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.-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
1101 POLIOVIRUS TYPE 1.....		1									
1102 POLIOVIRUS TYPE 2.....		2									
1103 POLIOVIRUS TYPE 3.....							1				
1104 POLIOVIRUS-VACCINAL STRAIN....						1	2				
1200 MUMPS VIRUS.....			1	3		1					1
1300 HERPES VIRUS GROUP-NOT TYPED..		1	1	2				1			8
1301 HERPES SIMPLEX VIRUS NOT-TYPED	1	2	1								42
1303 VARICELLA-ZOSTER VIRUS.....	2			1		1					4
1306 HERPES SIMPLEX TYPE 1.....		1	1				1			1	26
1307 HERPES SIMPLEX TYPE 2.....			1								6
1401 COXIELLA BURNETI.....	11	5									
1515 CONTAGIOUS PUSTULAR DERMATITIS (ORF VIRUS).....											2
1521 MEASLES VIRUS.....			2	1							8
1522 RUBELLA VIRUS.....	1										19
1532 HEPATITIS B ANTIGEN.....	29							27			
1535 HEPATITIS A ANTIBODY.....								6			
1555 PAPOVAVIRUS GROUP (PAPILLOMA-HUMAN WART).....											1
1556 CMV - CYTOMEGALOVIRUS.....	4	8	1					1	1	5	1
1563 CORONAVIRUS.....							1				
1564 ROTAVIRUS.....	3						22				
POXVIRUS GROUP NOT TYPED											1
DENGUE (TYPE 3)	1										
Total.....	65	140	8	21		3	43	38	2	6	128

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

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PERIOD : 13/11/80 to 26/11/80 ... 80/24

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
0100 ADENOVIRUS NOT TYPED.....	3						1		2	
0101 ADENOVIRUS TYPE 1.....								1	1	
0102 ADENOVIRUS TYPE 2.....						1	1	1		
0103 ADENOVIRUS TYPE 3.....	1									
0107 ADENOVIRUS TYPE 7.....	1								1	
0111 ADENOVIRUS TYPE 11.....		1								
0119 ADENOVIRUS TYPE 19.....		7								
0201 INFLUENZA A VIRUS.....					3		3	2		
0202 INFLUENZA A VIRUS SUBTYPE H3N2							1	2		
0203 INFLUENZA B VIRUS.....					2		1	5	2	
0301 PARAINFLUENZA VIRUS TYPE 1....					1			1		
0303 PARAINFLUENZA VIRUS TYPE 3....							1			
0400 RESPIRATORY SYNCYTIAL VIRUS (RS).....						1				
0500 RHINOVIRUS (ALL TYPES).....	1							1		
0600 MYCOPLASMA PNEUMONIAE.....							4	1	1	
0700 ORNITHOSIS-PSITTACOSIS.....							2			
0800 COXSACKIEVIRUSES GROUP A - NOT TYPED.....					1					
0809 COXSACKIEVIRUS A9.....						1			1	
0902 COXSACKIEVIRUS B2.....								2		
1009 ECHOVIRUS TYPE 9.....			1					3		
1011 ECHOVIRUS TYPE 11.....								1		
1021 ECHOVIRUS TYPE 21.....							1			
1101 POLIOVIRUS TYPE 1.....				1						
1102 POLIOVIRUS TYPE 2.....										1
1200 MUMPS VIRUS.....			7		1					
1300 HERPES VIRUS GROUP-NOT TYPED..	2	8						2		

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE 6

PERIOD : 13/11/80 to 26/11/80 ... 80/24

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 ... **-CONTINUED**

VIRUS OR VIRAL ANTIGEN	Eye	Genital	Endo/sal gland	RES	Muscle/joint	Congenital	PUO	Fever/malaise	Other	SIDS
1301 HERPES SIMPLEX VIRUS NOT-TYPED	1	33							1	
1306 HERPES SIMPLEX TYPE 1.....	9	13					1			
1307 HERPES SIMPLEX TYPE 2.....		116						1		
1401 COXIELLA BURNETI.....					1		13	12		
1521 MEASLES VIRUS.....									1	
1522 RUBELLA VIRUS.....					2			3	1	
1541 CHLAMYDIA A - TRIC TYPE.....	1	139								
1556 CMV - CYTOMEGALOVIRUS.....		5				3	6	3	4	
ROSS RIVER VIRUS			1		7					
Total.....	19	322	9	1	18	6	35	41	15	1