AUSTRALIA

Bulletin Number 79/24
Issue Date: 7 December 1979

Communicable Diseases Intelligence

Virus reports this period - 808. Reports of interest include:

- Echovirus type 11 - 75 reports, compared with between 23 and 30 during each of the previous four reporting periods. In CDI 79/17, an outbreak with diverse symptomatology was reported in South Australia. This later spread to Victoria where approximately half of the cases presented as viral meningitis (CDI 79/21 and 79/22). It now appears that the outbreak is spreading northwards to New South Wales and Queensland.

  Reports this period included 25 from Victoria, of which 19 had meningitic symptoms, 34 from New South Wales and the A.C.T. (19 meningitic) and 14 from Queensland (6 meningitic) - i.e., over two-thirds presented as cases of aseptic meningitis. The remaining two reports were from Western Australia, both non-meningitic.

  The Commonwealth Serum Laboratory, Melbourne (CSL) also reported five additional isolations from university students with respiratory symptoms, some of whom also had headaches.

  A similar outbreak was reported in Western Australia earlier in the year (CDI 79/9), although the proportion of cases with meningitic symptoms was lower.

- Rectal herpes - The ICPMR, Sydney, reported four isolations of herpes from rectal smears. Three were type 2 and one type 1. This brings the total reported from this site during the year to 13, four being type 1, eight type 2, and one untyped.

- Influenza A - One isolation of subtype H_3N_2 was reported from Fairfield Hospital, Melbourne, from a two year old Vietnamese refugee from Malaysia. He had had a mild upper respiratory tract infection for nine days, but had only been in Australia for six days. This is the second reported isolation of this strain in recent months.

  In addition to the three reports of A(H_1N_1) isolations in the tables, CSL has advised of a fourth categorized as A/Brazil/11/78 from a college student in Victoria.

- Rubella - 43 reports - a decrease compared with the 74 reported last period, although similar in number to the previous few reporting periods. New Zealand has also reported a higher prevalence of this

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HEALTH STATUS OF INDO-CHINESE REFUGEES

Since 1974 more than a million refugees appear to have left Indo-China. About 400,000 have made their way to refugee camps; others have been rescued at sea, and some have successfully sailed as far as Northern Australia. Their plight has attracted considerable media attention, and some of our sister bulletins have reviewed aspects of their health status.[1,2,3,4,5] The report that follows presents the Australian experience, and uses data supplied by health authorities in New South Wales (4679 refugees from May 1977 to June 1979) and Western Australia (2217 refugees from May 1977 to November 1979). Information on some of the N.S.W. group has been published elsewhere.[6]

An estimated 26,057 Indo-Chinese refugees have entered Australia from all sources since 1974, and current policy is to accept 14,000 refugees annually. About 2,300 have entered Australia illegally on small boats. The remainder have entered from refugee camps in Thailand or Malaysia, and have been interviewed, medically examined, and where necessary treated, before embarkation.

Indo-Chinese refugees entering Australia are required to meet the same standards of medical fitness as immigrants from elsewhere. They thus receive a clinical examination and a chest X-ray (CXR) if aged 16 years or over. Children under 16 years are X-rayed if a member of their family has an abnormal CXR of if there is any suspicion of an abnormal chest condition.

In addition, Indo-Chinese refugees are:

1. serologically screened for syphilis. Circumstances limit the screening to a V.D.R.L. flocculation test performed by laboratories in the host countries;
2. given an appropriate dose of a suitable anti-helminthic drug (Combantrin) before embarkation. This is aimed to reduce the parasite load rather than effect a cure; and
3. re-examined 24 hours before departure for any infectious disease or condition which may have developed since the initial medical examination.

In Thailand, the site of migration selection of refugees destined for other countries is a holding camp near Bangkok, and most medical examinations are arranged there under the general supervision of the Australian medical director.

In Malaysia, the medical examinations are arranged by the Australian medical director in Kuala Lumpur. They are carried out in various parts of the Malaysian Peninsula and a number of adjacent islands, often involving considerable travel by air, car and small boat and primitive conditions.

The examination process is carefully coordinated with the requirements of other Governments and of other Australian authorities concerned with immigration. Despite the difficulties imposed by the numbers of refugees, language barriers, climate, and travel to examination sites, medical selection has generally been satisfactory.

Some of the conditions likely to be relevant to Australia are discussed below.

Tuberculosis. A prevalence of 680 active cases per 100,000 of population has been reported from South-East Asia.[7] An estimated 10% of the organisms are resistant to isoniazid (INH).[1]

Refugees identified on overseas screening as having active tuberculosis are given a standard treatment of streptomycin 1G, INH 400mg and pyrazinamide 1.5 G. daily, continued until departure. This daily regimen may be altered to bi-weekly after 6 weeks if side effects appear. Generally after 6-8 weeks treatment, although not cured, these patients are no longer infectious, and sputum smears are negative; cultures are not performed overseas.

All these patients are placed on a "tuberculosis undertaking" requiring that they place themselves under the care and surveillance of the Director of Tuberculosis of the States to which they migrate; details are sent to relevant State Health Officers.

Any person found with a 'calcified primary complex' or with other old, stable, inactive calcified and/or fibrotic lesion is also placed on a tuberculosis undertaking but no treatment is given overseas.

N.S.W. reports 170 cases of active T.B. with 61 cases receiving chemoprophylaxis for evidence of past T.B. infection without active disease, or children at risk.

W.A. reports 76 cases of active and inactive T.B.

There is a 33.8% prevalence of Mantoux positivety amongst children less than 16 years (N.S.W.) compared with a prevalence of 1-2% in Australian schoolchildren.[6] However, unlike Australians, a significant proportion of these refugee children have had BCG vaccination, so not all the difference in prevalence reflects naturally occurring infection.

Hepatitis B. Particular concern has been expressed over the prevalence of hepatitis B antigenaemia in refugees; 20% in N.S.W.[6] and 11% in Canada[2] compared with an estimated 0.1% in the Australian population.[6] Generally the individuals are asymptomatic and carry the antigen chronically. However the high incidence is not considered to pose a major public health problem to receiving countries.[2,3] The presence of hepatitis B surface antigen (Hb_sAg) is associated with the capability of blood to be infectious but does not necessarily imply infectivity.[8] A better marker of infectivity is the e antigen (Hb_eAg) which is present in only a a small minority of Hb_sAg carriers[8]; this test is a research tool not available for general use.

Most transmission is thought to occur in situations of close or intimate contact when blood or serous exudate enters the body of a susceptible person through a break in the skin or penetrates through a mucous membrane or the eye. Body fluids containing Hb_sAg can contaminate environmental surfaces but there is no evidence that the virus can withstand routine cleaning, disinfection or sterilisation.

Thus transmission is not likely to occur to school-age contacts of carrier children under normal hygienic circumstances or to social or work contacts of adult carriers. Transmission is also unlikely to occur from

carriers employed as food handlers or as hospital personnel or from the use of public facilities.

However there is a greater likelihood of transmission to neonates (during childbirth), to certain health-facility personnel and possibly to host families sponsoring refugee families having young children.[3] Perinatal transmission is more common in Asian populations studied.[9] As dental problems are estimated at 80% (N.S.W.) and 23% (W.A.) amongst refugees dental personnel and oral surgeons are suggested to be at increased risk.[3] However a survey of Canadian dentists indicated that as a group they were not at increased risk of acquiring clinical hepatitis or becoming carriers but were more likely to have anti-Hb_S in the blood suggesting immunity to infection[10]. It has been suggested that dentists may acquire immunity by repeated low dose exposures.[11]

Preventive measures involve rejection as blood donors of all those potentially infected individuals and strict aseptic techniques by medical, dental and laboratory personnel dealing directly with patients or handling potentially infective blood or blood products.

Immune serum globulin and hepatitis immune globulin may confer protection against hepatitis B in some modes of transmission[4], it has recently been suggested for use in neonates of carrier mothers.[12]

Malaria. Malaria is endemic in a number of areas of South-East Asia from which the refugees either have originated or which they have passed through. The importation of the malaria from these areas is mainly Plasmodium vivax, less commonly P. falciparum. Chloroquine resistant strains of P. falciparum are found in some of the areas. Identification and treatment of infected refugees is essential as some of them may settle in malarial receptive areas of Australia. Routine thick blood films are not performed overseas because of difficulties of preparation. Most States perform these routinely on entry. (Few cases of malaria have been detected in the refugees - 7 in N.S.W. and 2 in W.A.)

Sexually transmitted diseases. The prevalence of sexually transmitted disease amongst refugees is reported by the U.S.A. to be very low. However serological tests within Australia have indicated treponemal infections in 69 (N.S.W.) and 44 (W.A.). Although overseas screening is adequate for the majority of cases of infectious syphilis, it is advisable that additional specific treponemal tests be performed in Australia. Non infectious syphilis is not a public health problem but may progress to produce a major personal health problem.

Strains of gonorrhoea from South-East Asia may be relatively resistant to a variety of antibiotics but no data from refugees are available.

Enteric diseases. Although stool cultures are not done routinely, intestinal parasites are common. Intestinal helminths do not pose a significant public health hazard since adequate sewage disposal interrupts transmission of the helminths, which require several days of incubation in soil before becoming infective. Adequate hygienic practices also minimize the risk posed by intestinal protozoa.

W.A. reported 546 refugees (27% of total) as having intestinal parasites. Of the parasites found the most common were Ascaris lumbricoides (62%), Trichuris trichiura (16%), Ancylostoma duodenale (12%), Giardia lamblia (8%) and Strongyloides stercoralis (2%). Ninety-six cases of Salmonellae (5% of total) and 13 of Shigellae (1%) were also reported. A few Salmonella typhi isolations have recently been reported from Victoria.[13]

Other diseases. Skin infections are relatively common and may be multiple. N.S.W. reports 1115 skin diseases 49% of which were pediculosis, 26% fungal and 25% scabies. W.A. figures which relate to the refugee population indicate a 10% prevalence of scabies and 6% fungal skin infections.

55 cases of trachoma (3%) were also noted from W.A. Leprosy has been rarely reported (1 for N.S.W., 2 for W.A.). More than 70% of leprosy seen in South-East Asia is of the tuberculoid variety which is relatively non-infectious.[14,15]

Latent infections. These may cause individual problems and present diagnostic difficulties long after migration. Diseases which may have to be considered include melioidosis, typhoid and the parasites of shistosomiasis, filariasis, paragonimiasis and very rarely P. malariae.[16]

Immunization. The immunization status of most of the refugees is inadequate and should be carefully evaluated. It is necessary to protect the immigrants and Australian residents from vaccine preventable diseases by ensuring up to date immunization. Positive cultures of Corynebacterium diphtheriae from an adult refugee have recently been reported in the U.S.A.[17], and a surveillance programme for diphtheria has commenced in Canada.[18]

Haemoglobinopathies. There is an increased prevalence of haemoglobinopathies amongst the refugees. Thalassaemia trait is reportedly 3% (W.A.). An estimated 10-12% of nationals from South-East Asia have at least some level of glucose-6-phosphate dehydrogenase deficiency.[1] Haemolytic anaemia has been precipitated in some Indo-Chinese patients receiving trimethoprim sulphur methoxazole[3] and primaquine[1]; screening may be necessary before the administration of these drugs.

In summary it seems generally considered by Western countries accepting refugees that[1]:

1. the majority will be free of major contagious diseases;
2. where an illness is present it will likely represent a personal rather than a public health problem, and
3. the main health problems, perhaps exceeded only by the stress of resettlement itself, will include tuberculosis and parasitic diseases.

Assistance and data for this review were supplied by Dr A.L. Lyons, Migrant Health Unit, Dept. of Health, Canberra, and Drs A. Moynham and P. Christopher, Health Commission of N.S.W.

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Isolations of Yersinia spp. from human sources

Since the request in CDI 79/22 for reports of isolations of Yersinia spp from human sources, one report has been received from the Bacteriology Department of the Repatriation General Hospital, Hobart, Tasmania.

Six isolations of Yersinia enterocolitica were obtained from human faeces during the period 11/6/79 to 16/10/79. The organisms were isolated from four middle-aged men with diarrhoea. Two patients had two biochemically different strains.

The isolations were made from low temperature enrichments of faeces in phosphate-buffered saline after 10 to 21 days incubation at 4°C. Primary cultures were negative for Yersinia enterocolitica. Because of the delay of up to 3 weeks in reporting, the significance of the isolations is uncertain.

(continued from page 6 - Rubella)

disease recently. The situation is being watched closely in view of the possibility of there being an epidemic similar to that in the northern hemisphere earlier in the year.

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE 2

REPORTING PERIOD - 15 - 11 - 79 . 28 - 11 - 79 BULLETIN NUMBER 79 24
VIRAL IDENTIFICATIONS FROM CONTRIBUTING LABORATORIES

VIRUS OR VIRAL ANTIGEN	ICPMR (NSW) / WVH (ACT)	RAHC (NSW)	PHR/ POW (NSW)	FAIR-FIELD (VIC)	RCH (VIC)	IMVS (SA)	STATE LAB (QLD)	STATE LAB (WA)	Total
0100 ADENOVIRUS NOT TYPED	4		3	1	1	2	6	2	19
0101 ADENOVIRUS TYPE 1				1					1
0102 ADENOVIRUS TYPE 2				3		1		2	6
0103 ADENOVIRUS TYPE 3		1				2			3
0104 ADENOVIRUS TYPE 4						2		1	3
0106 ADENOVIRUS TYPE 6						1		1	2
0107 ADENOVIRUS TYPE 7			2	3		1			6
0111 ADENOVIRUS TYPE 11				1					1
0119 ADENOVIRUS TYPE 19				2				4	6
0199 ADENOVIRUS TYPING PENDING					7	1			8
0201 INFLUENZA A VIRUS	1		1				1		3
0202 INFLUENZA A VIRUS SUBTYPE H3N2				1					1
0203 INFLUENZA B VIRUS							3		3
0301 PARAINFLUENZA VIRUS TYPE 1	2								2
0302 PARAINFLUENZA VIRUS TYPE 2				1	2		1		4
0303 PARAINFLUENZA VIRUS TYPE 3	1	2		2	10	2	1	3	21
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	2				1	6	1		10
0500 RHINOVIRUS (ALL TYPES)				2	7	6		1	16
0600 MYCOPLASMA PNEUMONIAE	7		2			10	6	2	27
0700 ORNITHOSIS-PSITTACOSIS	4								4
0800 COXSACKIEVIRUSES GROUP A - NOT TYPED								1	1
0809 COXSACKIEVIRUS A9	6		1	1	1				9
0902 COXSACKIEVIRUS B2		1							1
0903 COXSACKIEVIRUS B3		1							1
0904 COXSACKIEVIRUS B4	2		1	1		1	3	4	12
1004 ECHOVIRUS TYPE 4								1	1
1005 ECHOVIRUS TYPE 5	2								2
1007 ECHOVIRUS TYPE 7						1			1
1011 ECHOVIRUS TYPE 11	19	9	6	17	8		14	2	75
1013 ECHOVIRUS TYPE 13	1								1
1014 ECHOVIRUS TYPE 14						1			1

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE 2

REPORTING PERIOD - 15-11-79 . 28-11-79 BULLETIN NUMBER 79.24

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
1017 ECHOVIRUS TYPE 17								1	1
1019 ECHOVIRUS TYPE 19			1				1		2
1022 ECHOVIRUS TYPE 22		1		2	6	1			10
1026 ECHOVIRUS TYPE 26						1			1
1030 ECHOVIRUS TYPE 30				1					1
1032 ECHOVIRUS TYPE 32			1						1
1101 POLIOVIRUS TYPE 1				1				2	3
1104 POLIOVIRUS-VACCINAL STRAIN					1				1
1105 POLIOVIRUS SABIN						1			1
1200 MUMPS VIRUS	13		5	10	1		3	2	34
1300 HERPES VIRUS GROUP-NOT TYPED	1			2		1		2	6
1301 HERPES SIMPLEX VIRUS-NOT TYPED	10		4	5	4	1	18	41	83
1302 EPSTEIN-BARR VIRUS (EB VIRUS)						3			3
1303 VARICELLA-ZOSTER VIRUS	2		2	4		1	1		10
1306 HERPES SIMPLEX TYPE 1	7		1	14		11			33
1307 HERPES SIMPLEX TYPE 2	29		2	29		13			73
1399 HERPES VIRUS TYPING PENDING						1		1	2
1401 COXIELLA BURNETI	9			4			13		26
1502 PICORNA VIRUS-NOT TYPED								1	1
1521 MEASLES VIRUS			2	3		8	1		14
1522 RUBELLA VIRUS	5	1	1			7	18	11	43
1530 HEPATITIS A VIRUS								4	4
1532 HEPATITIS B ANTIGEN	1		11	25		6	7	6	56
1535 HEPATITIS A ANTIBODY						3			3
1541 CHLAMYDIA A - TRIC TYPE	21		4					34	59
1556 CMV - CYTOMEGALOVIRUS	2		7	25	1	4		3	42
1564 ROTAVIRUS			2	1	5	4			12
1599 ENTEROVIRUS TYPING PENDING		5	3		14	1			23
ROSS RIVER VIRUS							5	2	7
ASTROVIRUS	1								1
SMALL VIRUS (LIKE) PARTICLE				1					1
Total	152	21	62	164	69	104	103	134	809

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE

REPORTING PERIOD - 15-11-79 - 28-11-79 BULLETIN NUMBER 3 79-24

VIRAL IDENTIFICATIONS CATEGORISED INTO SOURCE SPECIMENS

VIRUS OR VIRAL ANTIGEN	FA	BL	NA	CS	SK	EY	UR	BR	GE	OT	TOTAL
0100 ADENOVIRUS NOT TYPED	6	5	7			2					20
0101 ADENOVIRUS TYPE 1			1								1
0102 ADENOVIRUS TYPE 2	2		4								6
0103 ADENOVIRUS TYPE 3	1		1			1					3
0104 ADENOVIRUS TYPE 4	2					1					3
0106 ADENOVIRUS TYPE 6	1		1								2
0107 ADENOVIRUS TYPE 7	2		4				1				7
0111 ADENOVIRUS TYPE 11	1			1							2
0119 ADENOVIRUS TYPE 19						3			3		6
0199 ADENOVIRUS TYPING PENDING	4		3			1					8
0201 INFLUENZA A VIRUS		3									3
0202 INFLUENZA A VIRUS SUBTYPE H3N2			1								1
0203 INFLUENZA B VIRUS		1	2								3
0301 PARAINFLUENZA VIRUS TYPE 1			2								2
0302 PARAINFLUENZA VIRUS TYPE 2		1	3								4
0303 PARAINFLUENZA VIRUS TYPE 3		2	18							1	21
0400 RESPIRATORY SYNCYTIAL VIRUS (RS)	1	2	7								10
0500 RHINOVIRUS (ALL TYPES)			16								16
0600 MYCOPLASMA PNEUMONIAE		27									27
0700 ORNITHOSIS-PSITTACOSIS		4									4
0800 COXSACKIEVIRUSES GROUP A - NOT TYPED	1										1
0809 COXSACKIEVIRUS A9	2		2	5							9
0902 COXSACKIEVIRUS B2				1							1
0903 COXSACKIEVIRUS B3				1							1
0904 COXSACKIEVIRUS B4	5		3	4	1		1			1	15
1004 ECHOVIRUS TYPE 4										1	1
1005 ECHOVIRUS TYPE 5			2								2
1007 ECHOVIRUS TYPE 7	1										1
1011 ECHOVIRUS TYPE 11	18		31	35	1		1			3	89
1013 ECHOVIRUS TYPE 13	1										1
1014 ECHOVIRUS TYPE 14	1										1
1017 ECHOVIRUS TYPE 17			1								1

AUSTRALIA - COMMUNICABLE DISEASES INTELLIGENCE 4

REPORTING PERIOD - 15-11-79 - 28-11-79 BULLETIN NUMBER 79 . 24
VIRAL IDENTIFICATIONS CATEGORISED INTO SOURCE SPECIMENS-CONTINUED

VIRUS OR VIRAL ANTIGEN	FA	BL	NA	CS	SK	EY	UR	BR	GE	OT	TOTAL
1019 ECHOVIRUS TYPE 19	1		1								2
1022 ECHOVIRUS TYPE 22	8		2								10
1026 ECHOVIRUS TYPE 26	1										1
1030 ECHOVIRUS TYPE 30				1							1
1032 ECHOVIRUS TYPE 32	1										1
1101 POLIOVIRUS TYPE 1			3								3
1104 POLIOVIRUS-VACCINAL STRAIN	1										1
1105 POLIOVIRUS SABIN	1										1
1200 MUMPS VIRUS		17	8	11							36
1300 HERPES VIRUS GROUP-NOT TYPED					4					2	6
1301 HERPES SIMPLEX VIRUS-NOT TYPED		9	11	1	28				33	3	85
1302 EPSTEIN-BARR VIRUS (EB VIRUS)		3									3
1303 VARICELLA-ZOSTER VIRUS		6			4						10
1306 HERPES SIMPLEX TYPE 1	1		9		16				4	4	34
1307 HERPES SIMPLEX TYPE 2	3		2		3				67		75
1399 HERPES VIRUS TYPING PENDING									2		2
1401 COXIELLA BURNETI		26									26
1502 PICORNA VIRUS-NOT TYPED	1										1
1521 MEASLES VIRUS		9	5								14
1522 RUBELLA VIRUS		43									43
1530 HEPATITIS A VIRUS		4									4
1532 HEPATITIS B ANTIGEN		56									56
1535 HEPATITIS A ANTIBODY		3									3
1541 CHLAMYDIA A - TRIC TYPE						1			58		59
1556 CMV - CYTOMEGALOVIRUS		17	6	1			15		4	6	49
1564 ROTAVIRUS	12										12
1599 ENTEROVIRUS TYPING PENDING	12		6	5						2	25
ROSS RIVER VIRUS		7									7
ASTROVIRUS	1										1
SMALL VIRUS (LIKE) PARTICLE	1										1
Total	93	245	163	66	57	9	18		171	23	844

NOTIFIABLE DISEASES REPORTED IN AUSTRALIA

.11th 4 Weekly Period for 1979...

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6.10.79 to 2.11.79 inclusive

DISEASE	Total	N.S.W.	VIC	QLD	S.A.	W.A.	T.S.	N.T.	A.C.T.	CUMULATIVE TOTAL TO DATE FOR YEAR
Amoebiasis										15
Ankylostomiasis										* 136
Anthrax										1
Arbovirus infection	8		2	6						59
Brucellosis	3	1	1	1						46
Campylobacter infections										—
Chancroid	2			2						17
Cholera										* 1
Congenital rubella syndrome										—
Diphtheria										—
Donovanosis	5			5						55
Giardiasis										—
Genital herpes										—
Gonococcal ophthalmia neonatorum										—
Gonorrhoea	792	252	178	168	59	48	10	52	25	* 9996
Hepatitis A (infectious)	109	42	24	8	5	4	10	4	12	* 1599
Hepatitis B (serum)	62	10	23	10	17	1		1		669
Hepatitis - unspecified	5					3		2		* 69
Hydatid disease	4	2	1						1	23
Lassa Fever										—
Legionnaires disease										—
Leprosy	4					3		1		43
Leptospirosis	3		2		1					47
Lymphogranuloma venereum										1
Malaria	23	5	6	7	1	1			3	304
Marburg Disease										—
Meningococcal infections	5			5						70
Non-specific urethritis										—
Ornithosis	1	1								10
Pertussis (whooping cough)	2		2							163
Plague										—
Poliomyelitis										—
Q. fever	39	2	6	28	3					497
Rabies										—

DISEASE	Total	N.S.W.	VIC	QLD	S.A.	W.A.	TAS.	N.T.	A.C.T.	CUMULATIVE TOTAL TO DATE PER YEAR
Salmonella infections	68	6	10	8	25	9		8	2	1556
Shigella infections	59		1	2	2	13		41		* 527
Smallpox										—
Syphilis	342	61	16	161	30	15		58	1	* 2710
Tetanus	1			1						11
Trachoma										1
Tuberculosis (all forms)	125	59	20	20	8	12		3	3	* 1373
Typhoid fever	1	1								21
Typhus (all forms)										2
Vibrio parahaemolyticus infections										—
Yellow Fever										—
Yersinia enterocolitica infections										—

Data collected under the Notificable 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.

* Corrections made to the cumulative total since last report.

Ankylostomiasis + 5 cases for N.T.

Cholera + 1 case for Vic.

Gonorrhoea + 1 case for W.A.
- 16 cases for Vic
- 2 cases for N.T.

Hepatitis A - 6 cases for W.A.

Hepatitis Unspecified + 6 cases for W.A.

Shigella Infections + 2 cases for N.T.

Syphilis - 2 cases for W.A.
+ 6 cases for Vic.
+ 7 cases for S.A. and
+ 9 cases for N.T.

Tuberculosis - 1 case for A.C.T.