COMMUNICABLE DISEASES REPORT, NSW, FOR SEPTEMBER–OCTOBER 2004

For updated information, visit the website **www.health.nsw.gov.au** and click on the link to Infectious Diseases.

TRENDS

The NSW Department of Health's infectious diseases webpage has recently been enhanced to include graphs and tables showing the number of cases of various infectious diseases notified by doctors, hospitals, and laboratories. Data are usually updated on a daily basis, and show aggregate cases by the age and sex over time. To check reports for a particular disease, click on **www.health.nsw.gov.au/living/infect.html**, scroll down the table to the disease of interest, and click on the column headed 'NSW data'.

Tables 2 and 3 and Figure 1 show reports of communicable diseases received through to September and October 2004 in NSW. These data show a upswing in reports of **pertussis** from March through to September 2004, and a subsequent decline (see www.health.nsw.gov.au/data/diseases/pertussis.html). Over the last year, the group with the most notifications has been children aged 10–14 years. To help control ongoing outbreaks in this group, The NSW Department of Health has offered Australian Government-funded vaccination to high school children against pertussis, diphtheria and tetanus since mid-2004 (see **www.health.nsw.gov.au/living/immunisation/school_prog/index.html for details**). Pertussis can cause a serious illness that is characterised by a long lasting cough that can occur in bouts. Coughing bouts are sometimes followed by vomiting, or a gasping for air (or 'whoop'). In older children and adults, the ongoing bouts of coughing may be the only complaint. People with these symptoms should seek advice from their doctor, who can make a diagnosis (often with the assistance of laboratory tests of blood or respiratory sample tests) and if necessary, prescribe specific antibiotics to help prevent the further spread of the disease. Close contacts of patients with pertussis should watch out for symptoms, and those at high risk may need to take specific antibiotics to prevent infection. For more information, see **www.health.nsw.gov.au/pubs/2004/pert_cdfs.html**.

The expected seasonal increase in reports of **meningococcal disease** occurred in spring, although the winter–spring peak in 2004 was less than that seen in 2003 (see **www.health.nsw.gov.au/data/diseases/meningococcal.html**).

INFLUENZA OUTBREAKS IN RESIDENTIAL FACILITIES

In September 2004, 13 outbreaks of influenza-like illness were reported from residential institutions in 6 of the 17 area health service in NSW, including 12 aged care facilities and 1 correctional centre (Table 1). While institutions are not required to report influenza outbreaks under the *NSW Public Health Act*, reporting to public health units is encouraged to facilitate the prompt implementation of control measures.

Intervention

In response to these outbreaks, public health unit staff provided advice to facility managers on control measures.

TABLE1

REPORTS OF INFLUENZA-LIKE OUTBREAKS IN INSTITUTIONS, NEW SOUTH WALES, SEPTEMBER 2004

Facility	Area health service	Influenza-like illness in residents		Influenza-like illness in staff		Influenza confirmed in residents	Deaths in residents	
		N	%	*N*	%		*N*	%
ACF A	Hunter	38/50	76	20/59	34	Influenza A (3)	10	20
ACF B	Hunter	18/40	45	*		Influenza A (5)	*	
ACF C	Hunter	42/68	62	19/88	22	No	8	12
ACF D	Hunter	5/85	6	7/109	6	Influenza A (1)	*	
ACF E	Hunter	20/100	20	9/90	10	Influenza A (1)	*	
ACF F	Hunter	3/100	3	0/100	0	Influenza A (1)	*	
ACF G	Western Sydney	24/49	49	5/49	10	Influenza A (4)	2	4
ACF H	Wentworth	24/68	35	16/100	16	No	*	
ACF I	South Eastern Sydney	32/98	33	3/90	3	Influenza A (5) Influenza B (5)	2	2
ACF J	Northern Sydney	11/48	23	0/60	0	Influenza A (1)	*	
ACF K	Northern Sydney	20/57	35	25/60	42	Influenza A (1)	8	14
ACF L	Central Sydney	29/42	69	10/50	20	Influenza A (4)	4	10
Correctional Centre		23 (inmates)		1		Influenza A (6)	*	

ACF = aged care facility; * = none reported

The NSW Department of Health developed guidelines to assist managers of aged care facilities to minimise the spread of influenza within their institutions. The guidelines—*Controlling influenza outbreaks in aged care facilities*—was distributed by fax to ACFs throughout NSW, and included advice on:

- confirming the cause of respiratory outbreaks;
- forming an outbreak control team;
- isolating ill residents and restricting staff and visitors;
- performing regular hand hygiene;
- wearing masks when caring for ill residents;
- wearing gloves if contacting contaminated materials;
- wearing impervious gowns to protect clothing;
- enhancing cleaning;
- considering the use of anti-influenza medications for prophylaxis;
- immunising all staff and residents annually.

Comment

These outbreaks highlight the high attack rates (up to 76 per cent of residents and 42 per cent of staff) and death rates (up to 20 per cent in residents) associated with influenza outbreaks in aged care facilities, where residents at high risk for severe disease (because of their older age or concurrent illness) are clustered together.

The WHO Collaborating Centre for Influenza in Melbourne, reports that A/Fujian/411/2002-like (90 per cent) and B/Shanghai/361/2002-like (9 per cent) have been the most commonly identified influenza virus types identified in Australia through 2004. Data from NSW Health's Influenza Surveillance Report (see **www.health.nsw.gov.au/living/flureport.html**) suggest that influenza activity in the wider NSW community—as measured by attendance for influenza-like illness to selected general practitioners and emergency departments, as well as influenza diagnoses by major laboratories—began to increase in September in 2004, which is later than usual. However, influenza activity to date in 2004 appears lower than in 2002 and 2003 (when the Fujian strain of influenza A first appeared).

In previous years, NSW Health has not actively solicited reports of influenza outbreaks from institutions, or systematically collated information on reported outbreaks. The reasons for the apparent large number (13) reported in NSW in September 2004, and the large proportion of these reported from the Hunter Area are unclear, but one explanation could be improved reporting in 2004 following the release of the guidelines *Controlling influenza outbreaks in aged care facilities*. In addition, the first outbreak in the Hunter Area (in aged care facility A) was accompanied by substantial media interest that may in turn have led to improved reporting by other aged care facilities.

NSW Health provides Australian Government-funded influenza vaccine annually to residents of aged care facilities. However, in investigating many of these outbreaks, public health units found that residents' immunisation records did not provide clear evidence of vaccination, perhaps because the turnover of residents in aged care facilities was sometimes high and the immunisation status of new residents was not always assessed on admission.

The annual immunisation of both residents and staff before winter (when the influenza activity usually begins) is vital for limiting the extent of such outbreaks, even though vaccine efficacy declines in older people.[1] Managers of aged care facilities should ensure that record systems are in place to document the vaccination status of residents and staff, and flag the records of new residents and staff to ensure that they are offered immunisation. With growing evidence that anti-influenza medicines are effective in containing outbreaks,[1] managers of aged care facilities and clinicians should strongly consider their use to limit the spread of the infection in residential facilities.

Reference

1. Centers for Disease Control and Prevention. Prevention and control of influenza: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2003; 52(RR-8) available online at www.cdc.gov/mmwr/PDF/rr/rr5208.pdf.

UPDATE ON AVIAN INFLUENZA

There has been a recent increase in the reported number of outbreaks of highly pathogenic avian influenza (HPAI) among poultry flocks in Asia. Since the beginning of the epidemic in January 2004, (as of 5 October) 16 human cases (including 11 deaths) of laboratory-confirmed HPAI have been reported in Thailand, and 27 (including 20 deaths) have been reported in Vietnam. Most cases in humans are thought to have been acquired from direct or indirect exposures to infected poultry.

However, a probable case of person-to-person transmission of HPAI was reported in Thailand in September 2004. This transmission resulted from sustained, close personal contact between a mother and her sick child, and not because the virus had changed into a form that would facilitate the ready transmission from one person to another. Such transmission remains highly unusual. Disease control experts are concerned that while the HPAI epidemic in poultry smolders on, the propensity of the influenza virus to mutate will lead to a form that is more easily transmitted from person-to-person. If this were to occur, there is a possibility that an influenza pandemic could ensue.

Disease control activities in Asia to date have centred on active surveillance, culling of infected flocks, import–export restrictions, and movement restrictions around infected farms. Large-scale vaccination of poultry has been

advocated by some. Work to develop a human vaccine for the current strain in birds is ongoing. For updated information see the World Health Organization's website **www.who.int/csr/disease/avian_influenza/en**.

SALMONELLOSIS CLUSTER

In September, the NSW Department of Health was notified by the NSW Food Authority of gastrointestinal illness in children attending a birthday party. To identify the likely source of the illness, the Communicable Diseases Branch conducted a cohort study of those attending the party. Each person was asked for details of illness and the foods they ate at the party.

Four adults and 13 children aged from 12 to 15 years attended the party. Eleven of the children reported gastrointestinal illness following the party with symptoms including diarrhoea, fever and abdominal pain. None of the adults reported illness. *Salmonella* Typhimurium phage type 126 was isolated in stool specimens taken from 2 children.

Foods served at the party included commercially prepared pizza, sausage rolls, various chips and chocolates, and home-made tiramisu (an Italian dessert made with sponge, mascarpone cheese and raw egg). The association between each food eaten at the party and illness was calculated. The tiramisu was strongly associated with illness. Eleven of the 12 people who reported eating the tiramisu became ill (an attack rate of 92 per cent), while none of 6 who did not eat the tiramisu reported illness. There was no association between consuming other foods and reported illness. The 1 person who ate tiramisu and did not become ill was an adult who reported eating only a spoonful of the desert.

There are a number of ways food can be contaminated in the home. Cross-contamination from raw meat products to ready-to-eat foods, and undercooking contaminated foods are common causes of foodborne outbreaks. An environmental investigation is underway to better define the source of contamination of the tiramisu in collaboration with the NSW Food Authority.

UNUSUAL *SALMONELLA* SEROVAR AND EXPOSURE TO CATTLE

Peter Massey and Kylie Taylor

New England Public Health Unit

During April and September 2004, the New England Public Health Unit received 2 notifications of unusual serovars of *Salmonella*: *S.* Meleagridis and *S.* Stanley.

Salmonellosis can be a severe illness, characterised by sudden onset of headache, fever, abdominal pain, diarrhoea, nausea and sometimes vomiting. Dehydration can be severe, especially in the elderly or in infants. Complications such as septicaemia or localised infections can also occur. Death from salmonellosis is uncommon but morbidity associated with the infection can be substantial.[1]

There are over 1,800 known *Salmonella* serovars that current classification considers to be separate species. *S.* Typhimurium and *S.* Enteritidis serovars cause the large majority of human infections.

In NSW, a diagnosis of salmonellosis by laboratories is notifiable to public health units. To determine the cause of illness, the New England Public Health Unit investigated each case and their likely source of infection.

Investigation

Case 1

The notification in April 2004 was of a 3-month old child with *S.*Meleagridis infection. The child was reported by a general practitioner to have a fever and diarrhoea. The child was fully breastfed. The investigation identified that the child was washed in the shower while being held by its mother. The child ingested water by sucking it from its mother's arms while in the shower. The water supply to the house came directly from a creek and is untreated. Cattle cross the creek upstream from where the water is sourced.

Case 2

In September 2004, a 26-year old person with *S.*Stanley infection was notified to the New England Public Health Unit. The person was reported to have had a diarrhoeal illness for approximately 6 months. The case was interviewed for possible exposures. The most likely source of infection was frequent exposure on the hands and face to water used for cleaning at an abattoir.

Discussion

The National Enteric Pathogen Surveillance Scheme (NEPSS) reports that no human cases of *S.*Meleagridis have been recorded since 2001. The serovar has been found in some foods during 2002, in chicken litter and equine intestine,[2] in tree nuts and meat–bone meal.[3] Testing of the water into the house of the case with *S.* Meleagridis did not reveal any *Salmonella* bacteria. As no other possible exposure could be found, it is hypothesised that the child was infected from the water source via the shower.

*S.*Stanley is reported to be more common than *S.*Meleagridis. The NEPSS report that in NSW there were 12 cases reported to the end of October 2004, 11 cases in 2003, and 15 cases in 2002. The serovar has been found in some food sources, mainly porcine in recent years, but also in macadamia nuts and imported Chinese peanuts in 2001.[4] The serovar has also been reported from faecal samples of various animals.

The investigation into these unusual serovars highlight some issues about the surveillance and control of *Salmonella*:

- unusual serovars can indicate unusual types of exposures;
- direct or indirect contact with cattle may result in infection with *Salmonella*;
- untreated water may provide a vehicle for spreading the bacteria.

References

1. Heymann DL (editor). *Control of Communicable Diseases Manual: 18th Edition*. Washington, DC: American Public Health Association, 2004.
2. Davos D (editor). Australian *Salmonella* Reference Centre 2002 Annual Report. Adelaide: Institute of Medical and Veterinary Science, 2002.
3. Davos D (editor). Australian *Salmonella* Reference Centre 2003 Annual Report. Adelaide: Institute of Medical and Veterinary Science, 2003.
4. Davos D (editor). Australian *Salmonella* Reference Centre 2001 Annual Report. Adelaide: Institute of Medical and Veterinary Science, 2001.

Q FEVER CLUSTER IN A SHEARING TEAM

Peter Massey and Kylie Taylor
New England Public Health Unit

During August 2004, the New England Public Health Unit received 10 notifications of Q fever, representing a monthly rate (64.8/100000 population), well above the rate for all of 2003 (34.0/100000).

Q fever is sometimes a severe illness characterised by sudden onset of fever, chills, headache, weakness and sweats. Pneumonitis, hepatitis, endocarditis and neurological complications may follow. It is caused by infection with *Coxiella burnetii*, a rickettsia, which is commonly carried by a range of farm and wild animals. The infection is transferred to humans when they inhale droplets that are contaminated with the bacteria and which become aerosolised during the slaughter of an infected animal or through the discharge of products (urine, faeces, milk, and birth by-products) of an infected animal.[1] Q fever is mainly an occupationally-acquired disease in workers in the livestock, agriculture, and meat industries.

The abattoir industry in NSW has had an immunisation program in place for a number of years and subsequently the proportion of Q fever notifications in abattoir workers has decreased.[2] Cases are now predominately people working on the land who are associated with the livestock industry.[3]

In NSW, a diagnosis of Q fever by laboratories is notifiable to public health units. To determine the cause of the increase in notifications in August, the New England Public Health Unit investigated each case and their likely source of infection.

Investigation

The notifications in August 2004 for New England were of 9 males and 1 female. The age of these cases was 35–55 years. Each case had presented to their general practitioner. Reported symptoms included fever, chills, headache, myalgia, arthralgia, nausea and lethargy. One case required hospitalisation for pneumonia. All the cases reported that their illnesses lasted between weeks and months, and prevented them from working.

Five cases reported common risk factors: all worked on the same shearing team and had onset of their illness during a 3 week period in June–July 2004. The shearing team comprised 10 workers who had been shearing in the same shed at a property for some time. Two other members of the team were also reported to have signs and symptoms consistent with Q fever but did not seek medical advice. One case was the replacement shearer for another member who was off work with the illness. The attack rate in the team was 64 per cent (7/11).

Only 1 person in the shearing team reported having been immunised against Q fever, even though the Q fever immunisation had been available free as part of the national program. Two of the cases reported that some of the sheep in contact with the shearers at this property were lambing during the period of exposure.

Comment

Q fever remains a problem in rural NSW. In 2004 through to September, Macquarie (62.4/100000), New England (29.07/100000), and Far West (26.48/100000 areas all reported significantly higher notifications rates for Q fever than for NSW as a whole. Identification of clusters requires either the patient to be alert to the possibility, clinician reporting links among cases, or a public health investigation. In this cluster, because each case presented to a different doctor, it is unlikely that it would have been identified without a public health investigation.

Both direct and indirect contact with sheep has been shown to be a risk factor in outbreaks of Q fever mainly through airborne transmission.[4,5] High concentrations of *C. burnetii* are found in the birth by-products of infected animals.[6] Shearing brings people into very close contact with sheep and the confines of a shearing shed may also have contributed to the exposure.

We were unable to find data describing the immunisation rate among shearers, but this cluster indicates that there are agricultural workers who remain susceptible to this potentially debilitating disease.

This cluster highlights a number of issues about Q fever:

- the high attack rate in the 1 shed suggests that members of the shearing team may have had an

exposure from contact with the infected sheep and the environment of the shed may have increased this exposure;

- Q fever can cause an illness that is severe enough to interfere with shearing work and thus have economic consequences for rural families and communities;
- investigation of Q fever can detect clusters and contribute to our understanding of the disease and its risks;
- Q fever immunisation research into the barriers to the uptake of the immunisation by this group should be identified.

References

1. Centre for Epidemiology and Research, NSW Department of Health. *N S W Public Health Bull* 2002; 13(8): 191.
2. New England Public Health Unit (unpublished notifiable diseases data).
3. Boland PJ, Parker NR. Q fever in south west Queensland. *Med J Aust* 1999; 171(8): 446.
4. Manfredi et al. Investigation of a Q-fever outbreak in northern Italy. *Eur J Epi* 1996; 12(4): 403–8.
5. Lyytikainen et al. An outbreak of sheep associated Q fever in a rural community in Germany. *Eur J Epi* 1998; 14(2): 193–9.
6. Chin J (editor). *Control of Communicable Diseases Manual: 17th Edition*. Washington, DC: American Public Health Association, 2000; 407–411.

FIGURE 1

REPORTS OF SELECTED COMMUNICABLE DISEASES, NSW, JAN 1999 TO OCT 2004, BY MONTH OF ONSET

Preliminary data: case counts in recent months may increase because of reporting delays.

Laboratory-confirmed cases only, except for measles, meningococcal disease and pertussis

BFV = Barmah Forest virus infections, RRV = Ross River virus infections

lab+ = laboratory confirmed

Men Gp C and Gp B = meningococcal disease due to serogroup C and serogroup B infection, other/unk = other or unknown serogroups.

NB: multiple series in graphs are stacked, except gastroenteritis outbreaks.

NB. Outbreaks are more likely to be reported by nursing homes & hospitals than from other institutions

NSW population	
Male	50%
<5	7%
5–24	28%
25–64	52%
65+	13%
Rural*	42%

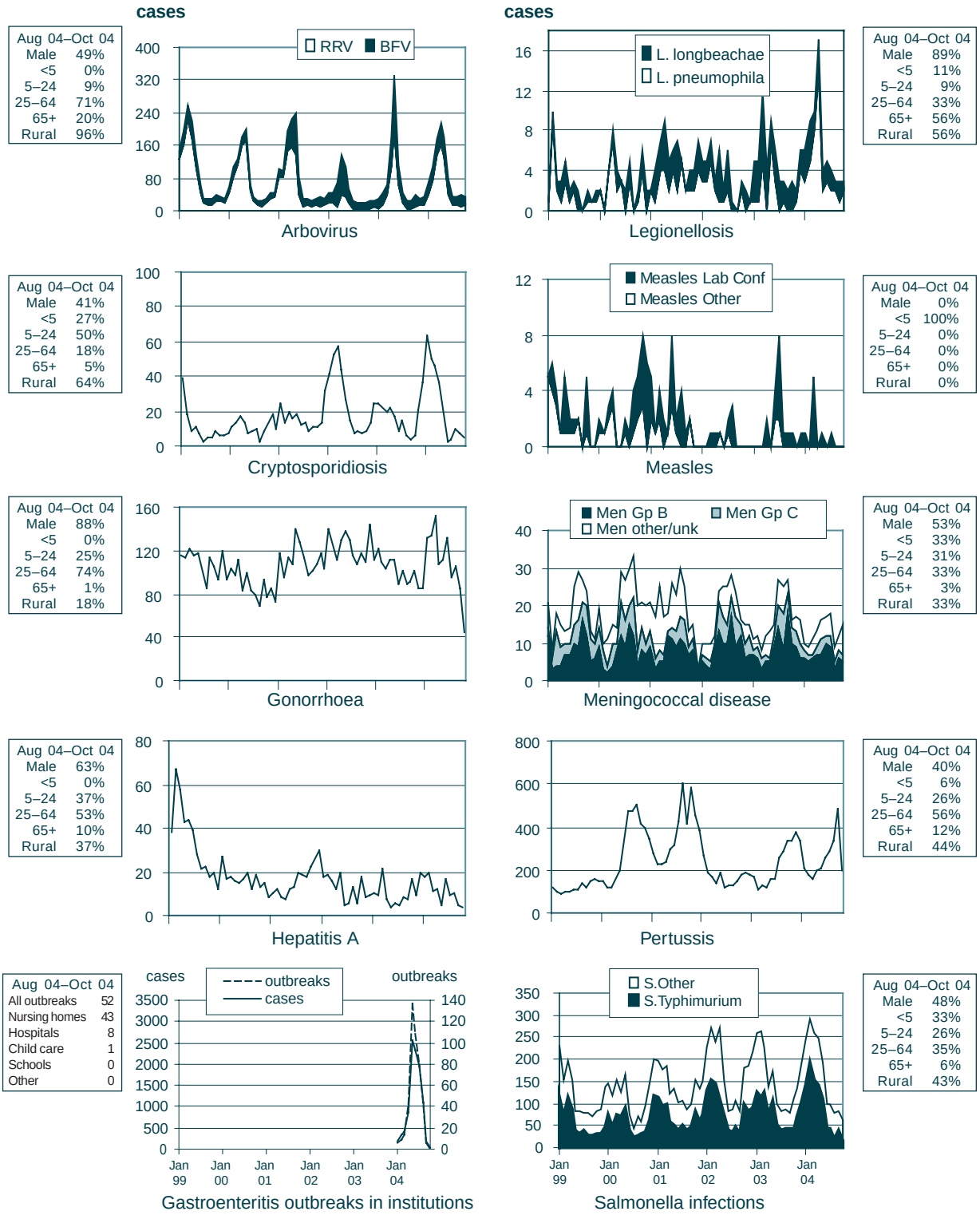

TABLE 2 REPORTS OF NOTIFIABLE CONDITIONS RECEIVED IN SEPTEMBER 2004 BY AREA HEALTH SERVICES

Condition	Area Health Service																		Total	
	CSA	NSA	WSA	WEN	SWS	CCA	HUN	ILL	SES	NRA	MNC	NEA	MAC	MWA	FWA	GMA	SA	CHS	for Sept†	To date†
Blood-borne and sexually transmitted																				
Chancroid*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chlamydia (genital)*	2	46	36	18	69	25	70	15	159	46	35	104	21	23	13	22	14	1	731	7272
Gonorrhoea*	9	5	3	2	3	1	5	1	44	3	2	12	1	-	1	-	-	-	93	999
Hepatitis B—acute viral*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	37
Hepatitis B—other*	18	31	61	5	96	7	1	5	41	3	3	-	1	4	2	1	2	2	285	2968
Hepatitis C—acute viral*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15
Hepatitis C—other*	54	19	52	30	85	39	29	25	84	25	38	9	10	12	2	11	7	9	546	5203
Hepatitis D—unspecified*	-	-	1	-	1	-	-	1	-	-	-	-	-	-	-	-	-	1	4	11
Syphilis	20	1	8	2	30	4	4	2	43	1	1	2	-	2	5	2	-	-	127	917
Vector-borne																				
Barmah Forest virus*	-	-	-	-	-	1	3	-	-	7	16	1	-	-	-	-	-	-	28	305
Ross River virus*	-	1	-	-	-	2	2	-	-	-	6	-	-	-	1	-	-	-	12	627
Arboviral infection (Other)*	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	1	31
Malaria*	-	1	3	-	1	-	-	-	3	-	-	1	-	-	-	-	-	-	9	68
Zoonoses																				
Anthrax*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Brucellosis*	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	1	5
Leptospirosis*	-	-	-	-	-	-	1	-	-	-	-	2	1	-	-	-	-	-	4	30
Lyssavirus*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Psittacosis*	-	-	-	-	1	-	3	-	-	1	-	-	-	1	-	2	-	-	8	55
Q fever*	-	-	2	-	-	1	2	-	1	2	-	3	9	-	2	-	1	-	23	164
Respiratory and other																				
Blood lead level*	1	-	-	1	5	1	-	1	-	1	2	1	4	-	2	-	-	-	19	220
Influenza*	7	27	41	7	38	3	16	6	91	8	-	-	3	3	-	1	1	2	254	515
Invasive pneumococcal infection*	5	8	22	2	15	4	11	7	19	3	4	-	-	2	1	1	-	-	104	724
Legionella longbeachae infection*	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	1	20
Legionella pneumophila infection*	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	39
Legionnaires- disease (Other)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Leprosy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4
Meningococcal infection (invasive)*	1	2	1	-	-	1	-	1	3	1	-	-	-	-	1	-	1	-	12	117
Tuberculosis	6	3	4	-	2	1	2	-	6	-	1	-	-	-	-	-	1	1	28	281
Vaccine-preventable																				
Adverse event after immunisation**	1	-	-	-	2	1	-	1	4	-	-	1	-	1	-	3	1	-	15	148
H. *Influenzae b* infection (invasive)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3
Measles	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	9
Mumps*	-	1	-	-	-	-	-	1	-	-	-	-	1	-	-	-	-	-	3	40
Pertussis	42	39	50	25	52	14	51	16	78	18	10	11	75	10	3	18	7	-	519	2365
Rubella*	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	15
Tetanus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Enteric																				
Botulism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Cholera*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Cryptosporidiosis*	-	-	1	-	-	-	-	-	-	-	1	1	1	2	-	-	-	-	6	257
Giardiasis*	4	20	15	7	8	1	5	4	7	1	4	4	1	4	2	1	5	-	93	971
Haemolytic uraemic syndrome	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5
Hepatitis A*	1	2	3	-	-	2	-	1	1	-	1	-	-	-	-	-	-	-	11	123
Hepatitis E*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6
Listeriosis*	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	23
Salmonellosis*	6	7	10	5	7	1	4	4	8	8	7	4	2	1	3	1	1	-	79	1658
Shigellosis*	-	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	65
Typhoid and paratyphoid*	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	26
Verotoxin producing *E. coli**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Miscellaneous																				
Creutzfeldt-Jakob disease	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4

* lab-confirmed cases only + includes cases with unknown postcode * * HIV and AIDS data are reported separately in the *NSW Public Health Bulletin* each quarter

** AEFIs notified by the school vaccination teams during the National Meningococcal C Program are not included in these figures. These notifications are reviewed regularly by a panel of experts and the results will be published quarterly in the *NSW Public Health Bulletin* in 2004

CSA = Central Sydney Area
NSA = Northern Sydney Area
WSA = Western Sydney Area
WEN = Wentworth Area
SWS = South Western Sydney Area
CCA = Central Coast Area
HUN = Hunter Area
ILL = Illawarra Area
SES = South Eastern Sydney Area
NRA = Northern Rivers Area
MNC = North Coast Area
NEA = New England Area
MAC = Macquarie Area
MWA = Mid Western Area
FWA = Far West Area
GMA = Greater Murray Area
SA = Southern Area
CHS = Corrections Health Service

TABLE 3 REPORTS OF NOTIFIABLE CONDITIONS RECEIVED IN OCTOBER 2004 BY AREA HEALTH SERVICES

Condition	Area Health Service																		Total	
	CSA	NSA	WSA	WEN	SWS	CCA	HUN	ILL	SES	NRA	MNC	NEA	MAC	MWA	FWA	GMA	SA	CHS	for Oct†	To date†
Blood-borne and sexually transmitted																				
Chancroid*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chlamydia (genital)*	72	95	67	18	50	25	84	37	185	22	21	27	11	16	2	29	18	-	787	8219
Gonorrhoea*	13	7	10	-	3	3	4	4	164	2	2	-	-	-	-	-	-	-	213	1228
Hepatitis B—acute viral*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	37
Hepatitis B—other*	2	37	46	4	78	4	10	4	34	2	1	1	1	1	2	1	2	2	233	3257
Hepatitis C—acute viral*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	14
Hepatitis C—other*	67	23	41	20	79	32	36	21	61	17	20	8	7	19	1	12	16	7	464	5768
Hepatitis D—unspecified*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11
Syphilis	15	11	12	2	14	-	2	3	31	1	-	1	-	-	2	-	-	-	94	986
Vector-borne																				
Barmah Forest virus*	-	1	-	-	-	-	4	1	-	4	14	-	-	-	-	-	-	-	24	329
Ross River virus*	-	-	-	-	-	-	4	1	-	1	6	2	2	-	-	-	-	-	16	643
Arboviral infection (Other)*	-	-	-	-	-	-	-	-	2	-	1	-	-	-	-	-	1	-	4	35
Malaria*	-	-	2	-	2	1	1	1	1	-	-	-	-	-	-	3	-	-	11	78
Zoonoses																				
Anthrax*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Brucellosis*	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	6
Leptospirosis*	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-	-	-	-	2	32
Lyssavirus*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Psittacosis*	-	-	-	1	-	-	2	1	-	1	-	-	1	-	-	1	-	-	7	63
Q fever*	-	1	-	-	-	-	1	1	-	2	-	2	9	-	1	-	1	-	18	182
Respiratory and other																				
Blood lead level*	-	1	1	-	2	-	9	3	-	2	-	-	-	1	-	-	-	-	19	254
Influenza*	12	22	28	3	14	1	43	4	52	10	2	1	2	4	-	1	3	-	202	727
Invasive pneumococcal infection*	4	7	3	5	6	4	8	5	7	-	-	-	1	1	-	3	2	-	56	783
Legionella longbeachae infection*	-	-	1	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-	3	23
Legionella pneumophila infection*	-	-	-	-	-	-	-	1	-	-	-	-	-	1	-	-	-	-	2	42
Legionnaires- disease (Other)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Leprosy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4
Meningococcal infection (invasive)*	2	6	2	-	3	-	1	-	2	-	-	-	-	-	-	1	-	-	17	134
Tuberculosis	6	1	-	2	23	-	1	-	10	-	-	-	-	-	-	-	-	-	43	337
Vaccine-preventable																				
Adverse event after immunisation**	-	-	1	-	-	1	3	-	-	1	-	-	-	-	-	1	-	-	7	155
H. *Influenzae b* infection (invasive)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3
Measles	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	9
Mumps*	-	-	-	-	2	-	2	-	1	-	-	-	-	-	-	-	-	-	5	46
Pertussis	28	35	36	30	34	8	56	19	58	6	11	7	44	7	-	36	8	-	423	2797
Rubella*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	16
Tetanus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Enteric																				
Botulism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Cholera*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Cryptosporidiosis*	-	-	2	-	-	-	1	-	2	2	-	-	2	-	-	-	-	-	9	266
Giardiasis*	7	11	13	4	4	6	4	2	13	-	2	3	1	5	-	1	-	-	76	1051
Haemolytic uraemic syndrome	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	1	6
Hepatitis A*	1	-	-	-	2	-	-	-	-	2	-	-	-	-	-	-	-	-	5	126
Hepatitis E*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6
Listeriosis*	1	1	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-	-	4	27
Salmonellosis*	5	14	8	5	11	1	7	3	10	6	9	5	2	-	-	4	4	-	94	1756
Shigellosis*	4	-	-	-	-	-	-	-	1	1	3	3	-	-	-	-	-	-	12	78
Typhoid and paratyphoid*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	24
Verotoxin producing *E. coli**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Miscellaneous																				
Creutzfeldt-Jakob disease	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4

* lab-confirmed cases only + includes cases with unknown postcode * * HIV and AIDS data are reported separately in the *NSW Public Health Bulletin* each quarter

** AEFIs notified by the school vaccination teams during the National Meningococcal C Program are not included in these figures. These notifications are reviewed regularly by a panel of experts and the results will be published quarterly in the *NSW Public Health Bulletin* in 2004

CSA = Central Sydney Area
NSA = Northern Sydney Area
WSA = Western Sydney Area
WEN = Wentworth Area
SWS = South Western Sydney Area
CCA = Central Coast Area
HUN = Hunter Area
ILL = Illawarra Area
SES = South Eastern Sydney Area
NRA = Northern Rivers Area
MNC = North Coast Area
NEA = New England Area
MAC = Macquarie Area
MWA = Mid Western Area
FWA = Far West Area
GMA = Greater Murray Area
SA = Southern Area
CHS = Corrections Health Service