TIMELINESS AND COMPLETENESS OF REPORTING

The following table lists the number of weekly reports made to the Epidemiology and Health Services Evaluation Branch in the past two months, from Epiweek 28 to Epiweek 35.

There has been a major improvement in the quality of infectious diseases data received from Public Health Units (PHUs), both with respect to weekly reporting (Table 7) and the inclusion of basic epidemiological parameters on infectious disease notifications (Table 8).

TABLE 7

NUMBER OF WEEKLY REPORTS MADE TO EPIDEMIOLOGY BRANCH — JULY-AUGUST 1992

Public Health Unit	Number	Status
Central/Southern Sydney	8	Complete
Eastern Sydney	6	Complete
South Western Sydney	6	Incomplete
Western Sector	8	Complete
Northern Sydney	8	Complete
Central Coast	8	Complete
Illawarra	7	Complete
Hunter	8	Complete
North Coast	8	Complete
New England	8	Complete
Orana and Far West	8	Complete
Central West	8	Complete
South-West	8	Complete
South-East	7	Complete

TABLE 8

PERCENTAGE OF NOTIFICATIONS WITH INCOMPLETE INFORMATION BY VARIABLE AND AREA/REGION, JULY-AUGUST 1992

Area/Region	Age	Sex	Aboriginality
Central Sydney	complete	complete	38.7
Southern Sydney	complete	complete	44.5
Eastern Sydney	3.0	6.8	61.6
South Western Sydney	complete	complete	33.4
Western Sydney	1.8	0.9	25.0
Wentworth	complete	complete	33.4
Northern Sydney	4.6	3.4	25.8
Central Coast	complete	complete	100.0
Illawarra	complete	complete	76.5
Hunter	3.7	complete	100.0
North Coast	0.8	0.8	complete
New England	complete	1.8	25.0
Orana and Far West	2.7	complete	25.0
Central West	complete	complete	44.5
South-West	complete	complete	20.0
South-East	complete	complete	complete

PERTUSSIS (WHOOPING COUGH)

NSW faces the prospect of a pertussis epidemic in the 1992-93 summer and autumn. This prediction is based on three factors. First, pertussis epidemics have occurred in NSW at three- to four-year intervals, with recent epidemics in the summer/autumn months of 1985-6 and 1989-90. Second, to the end of August 1992, 75 pertussis notifications had been received in 1992, compared with 32 for the corresponding period in 1991 (Table 9). Third, the Australian Bureau of Statistics National Health Survey conducted in 1989-90 found that the NSW pertussis immunisation rate was only 89 per cent. Control of pertussis requires immunisation rates of more than 94 per cent.

TABLE 9

SUMMARY OF NSW INFECTIOUS DISEASE NOTIFICATIONS AUGUST 1992

Condition	Number of cases notified			
	Period		Cumulative	
	Aug 1991	Aug 1992	Aug 1991	Aug 1992
Adverse reaction	N/A	3	N/A	27
AIDS	30	1	238	93
Arboviral infection	7	3	454	274
Brucellosis	–	–	2	–
Cholera	–	–	–	1
Diphtheria	–	–	–	–
Foodborne illness (NOS)	279	3	2183	141
Gastroenteritis (instit.)	8	5	40	184
Gonorrhoea	38	15	274	275
H influenzae epiglottitis	1	3	11	31
H influenzae B — meningitis	7	9	27	69
H influenzae B — septicaemia	2	–	8	16
H influenzae infection (NOS)	9	3	90	23
Hepatitis A	145	17	551	667
Hepatitis B	155	42	858	1561
Hepatitis C	53	53	256	2273
Hepatitis D	N/A	–	N/A	5
Hepatitis, acute viral (NOS)	1	–	234	14
HIV infection*	67	62	534	514
Hydatid disease	2	–	4	4
Legionnaires' disease	–	–	22	75
Leprosy	–	–	–	5
Leptospirosis	–	1	23	14
Listeriosis	–	–	–	9
Malaria	21	2	147	85
Measles	28	13	244	232
Meningococcal meningitis	7	6	30	41
Meningococcal septicaemia	2	3	10	8
Meningococcal infection (NOS)	3	3	27	9
Mumps	N/A	–	N/A	15
Mycobacterial tuberculosis	41	10	196	245
Mycobacterial — atypical	16	–	77	159
Mycobacterial infection (NOS)	15	3	116	43
Pertussis	2	–	32	75
Plague	–	–	–	–
Poliomyelitis	–	–	–	–
Q fever	13	3	142	99
Rubella	5	1	28	30
Salmonella infection (NOS)	83	6	932	511
Syphilis	75	22	400	537
Tetanus	–	–	3	1
Typhoid and paratyphoid	2	1	40	21
Typhus	–	–	–	–
Viral haemorrhagic fevers	–	–	–	–
Yellow fever	–	–	–	–

*Data to July only

Three hundred and fifty-one cases of pertussis were recorded in the calendar years 1989-90. This was an underestimate of the true incidence, because the surveillance system in operation at the time was based on doctor notifications alone. The current system relies on hospital and laboratory as well as doctor notifications.

Of the 75 notifications received this year, sixty-eight (91 per cent) were for children over the age of six months, and could therefore have been prevented by age-appropriate immunisation.

Pertussis vaccine is one of the three components of Triple Antigen vaccine. No monovalent pertussis vaccine is available in Australia. A full course of immunisation

requires four injections of Triple Antigen, at the ages of two, four, six and 18 months.

To minimise the incidence of pertussis in the coming months, parents and medical attendants are urged to review the immunisation status of all children. Pertussis immunisation (Triple Antigen) can be given to any child under the age of four years.

The following public health measures should be taken if pertussis is diagnosed:

- Erythromycin should be given to cases to reduce transmission.
- Unimmunised household contacts aged less than five years should be excluded from child-care facilities for 14 days after the last exposure to infection, or until they have received five days of a 14-day course of erythromycin.

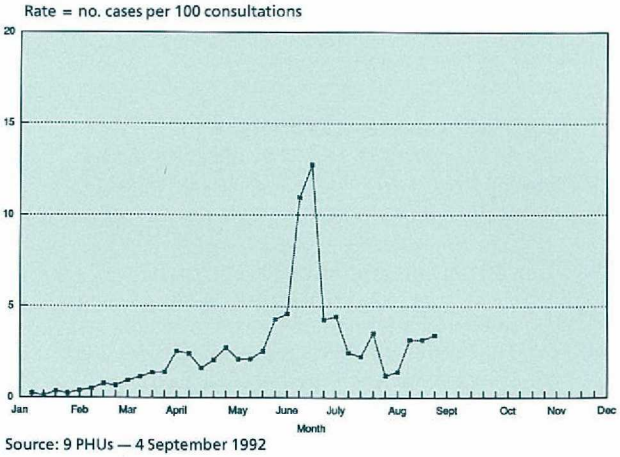
The role of pertussis immunisation is enhancement of immunity before exposure. Pertussis vaccine does not prevent infection after exposure has occurred.

INFLUENZA

Nine Public Health Units (CCA, CSA/SSA, CWR, ILL, ESA, NSA, SER, SWS and Western Sector) provide General Practitioner Sentinel Surveillance data on influenza. The August 1992 rate of influenza-like illness (ILI), expressed as the number of cases per 100 consultations averaged over all participating PHUs, ranged from 1.4 cases per 100 consultations in the first week of August to 3.4/100 consultations for the last week of August (Figure 3). Throughout August all participating PHUs, other than CWR, reported ILI rates of <5.0 cases per 100 consultations. CWR reported higher rates for the latter three weeks of August (12.2, 10.5 and 7.3/100 consultations).

FIGURE 3

INFLUENZA-GENERAL PRACTITIONER SENTINEL SURVEILLANCE NETWORK, NSW 1992



Source: 9 PHUs — 4 September 1992

HAEMOPHILUS INFLUENZAE type b

An effective and safe vaccine against *Haemophilus influenzae* type b has been available in Australia for four months for children between the ages of 18 months and five years.

Of the 139 notifications received for *Haemophilus influenzae* type b to the end of August 1992, 64 (46 per cent) occurred within the age range 18 months to five years, and could therefore have been prevented by immunisation.

The Department has recently released an information bulletin on *Immunisation for Haemophilus influenzae type B infections* (92/34).

MEASLES

Eighty-two per cent of notifications received in 1992 were for children over the age of one year. As measles immunisation is recommended at the age of 12 months, these cases were preventable by age-appropriate immunisation.

TUBERCULOSIS

Notifications received for tuberculosis are 25 per cent higher in 1992 than those reported for the same period in 1991. Reasons for this are:

- a true increase in the incidence of tuberculosis;
- improved surveillance of mycobacterial infections;
- improved data quality allowing most notifications to be correctly classified as tuberculosis or atypical mycobacteria; and
- Public Health Units not *denotifying* cases that do not fulfil clinical or epidemiological case definitions.

The NSW Health Department will be convening a meeting of Public Health, Infectious Disease and Thoracic Physicians on October 28 to discuss the following questions:

- Should tuberculin positive refugees and migrants be routinely offered chemoprophylaxis on arrival in Australia?
- Should isoniazid be the only drug used for routine chemoprophylaxis, as suggested by the NHMRC guidelines?
- Should fully supervised chemotherapy be given:
  — to all TB patients (as far as possible), and/or
  — where there is doubt about compliance, for example migrants with communication problems, alcoholics, elderly patients with poor memories, as suggested by the NHMRC guidelines, and/or
  — at the physician's discretion?
- For those known to have taken an adequate course of chemotherapy, how long should routine follow-up be continued?

The Community Health and Anti-tuberculosis Association is sponsoring the 1992 Tuberculosis Seminar on October 29. Further details can be obtained from TB Statewide Services on (02) 646 8576.

MENINGOCOCCAL MENINGITIS

Three children died of meningococcal meningitis in August-September — a two-year-old male from North Coast Region, a four-year-old female in South Eastern Region and a three-year-old male from the Hunter Area.

Notifications of meningococcal infections for the period January-August were 67 in 1991 and 58 in 1992, a decrease of 16 per cent. Notifications for meningococcal meningitis, for the same period, increased 37 per cent.

British and New Zealand Health Authorities have recently recommended that Benzylpenicillin should be carried in doctors' emergency bags and administered to all suspected cases of meningococcal disease before transfer to hospital. This will not affect the ability to confirm a diagnosis, as bacterial antigen will be identifiable in the cerebrospinal fluid.

Children referred to hospitals with a differential diagnosis of meningitis should be triaged appropriately to prevent unnecessary delays in diagnosis.

Continued on page 104 ►

► Continued from page 103

When meningitis is suspected in a child a lumbar puncture should be considered. No child should be discharged from hospital with a differential diagnosis of meningitis if a lumbar puncture has not been performed.

NON-NOTIFIABLE SEXUALLY TRANSMITTED INFECTIONS

Notifications of sexually transmitted infections[1] (STIs) which are not notifiable under the Public Health Act 1991 are being received from Sexual Health Clinics (SHCs) in nine Areas and Regions (Table 12). NSW is the only State in which such data are compiled. They will provide a means of describing the pattern of STIs managed in both urban and rural public SHCs.

Within three months Epidemiology and Health Services Evaluation Branch staff and members of the Venereology Society will devise case definitions and criteria for diagnosis and notification, so data are comparable among the Areas/Regions.

1. Previously referred to as *sexually transmitted diseases (STDs).*

GONORRHOEA — AUSTRALIAN GONOCOCCAL SURVEILLANCE PROGRAM — SYDNEY SECTION

One hundred and seventy-four gonococcal isolates have been examined from Sydney laboratories in the second quarter of 1992. This compares with 125 isolates for the same period in 1991, and 106 in 1990.

One-third of the isolates were penicillin-resistant. Three per cent of strains showed a decreased sensitivity to quinolones. Tetracycline resistance has also been detected.

A specific gonococcal strain, fully sensitive to penicillin, continues to be isolated in increasing numbers since its first appearance in 1990. Isolations are almost exclusively from males. Although the majority of sites have been urethral, a relatively high proportion of specimens were rectal.

PUBLIC HEALTH OFFICER OUTBREAK LOG

Since the inception of the training program in 1990 Public Health Officers (PHOs) have been closely involved in disease outbreak investigations throughout NSW, either as principal investigators or as part of an investigation team.

A disease outbreak log (Table 14) will be published periodically in the Public Health Bulletin. This will identify contact information for completed reports of disease investigations.

Copies of questionnaires used, correspondence, media communications and other field-tested procedural details may be made available.

HEPATITIS D

Between January and August 1992 the public health network received five reports of hepatitis D. All were males ranging in age from 24 to 38 years.

One case was reported from Eastern Sydney Area, one from Central Coast Area, one from Hunter Area and two from North Coast Region.

In Australia hepatitis D is most often seen in injecting drug users.

Hepatitis D virus (HDV) is always associated with hepatitis B virus (HBV), requiring the HBV for replication. HDV superinfection in a chronic HBV carrier often leads to severe chronic hepatitis, while acute HDV and HBV co-infection is usually associated with fulminant hepatitis.

TABLE 10

NSW HIV POSITIVE TESTS, EXCLUDING PREVIOUS POSITIVES, CUMULATIVE FROM 1984 TO JULY 31, 1992

Risk	Gender F	M	U	Total
Drug injecter	44	154	15	213
Haemophilia	0	62	0	62
Heterosexual	80	144	5	230[2]
Heterosexual + IDU	18	20	3	41
Homo/bisexual + IDU	—	85	4	90[2]
Homo/bisexual	—	4154	146	4301[2]
Not interviewed	0	3	0	3
Other	11	39	18	68
Transfusion	38	50	1	90[2]
Uncoded	3	5	0	8
Unknown	244	3860	1847	5952[2]
Vertical	7	12	4	23
Total	445	8588	2043	11081

TABLE 11

NSW HIV POSITIVE TESTS, EXCLUDING PREVIOUS POSITIVES, 1992 DATA

Risk	Gender F	M	U	Total
Drug injecter	2	6	0	8
Haemophilia	0	1	0	1
Heterosexual	8	21	2	31
Heterosexual + IDU	2	3	1	6
Homo/bisexual + IDU	0	10	0	11[3]
Homo/bisexual	—	234	9	243
Not interviewed	—	3	0	3
Other	1	3	0	4
Transfusion	0	1	0	1
Uncoded	0	0	0	0
Unknown	12	168	23	203
Vertical	0	3	0	3
Total	25	453	35	514

2. Includes people who give their sex as transsexual.
3. Includes one person who gave sex as transsexual.

HUMAN IMMUNODEFICIENCY VIRUS

The pattern of risk factors for 1992 differs from that observed in the cumulative data set in several respects.

- In the cumulative data set, 54 per cent and 18 per cent of notifications respectively lack risk factor and sex information (Table 10). In the 1992 data, these have reduced to 39 per cent and 7 per cent respectively (Table 11).
- The number of notifications associated with heterosexual exposure has increased from 5 per cent in the cumulative data (Table 10) to 12 per cent in the 1992 data (Table 11) (these are percentages of the notifications for which risk factor data are available). Correspondingly, the proportion of notifications specifying homosexual exposure has decreased slightly, from 86 per cent in the cumulative data (Table 10) to 82 per cent in the 1992 data (Table 11).

TABLE 12

NOTIFICATIONS OF NON-NOTIFIABLE SEXUALLY TRANSMITTED INFECTIONS BY AREA HEALTH SERVICE/REGION

[1] 1/1/92-31/7/92
[2] 1/1/92-30/6/92
[3] 1/3/92-31/7/92
[4] 1/5/92-31/8/92
[5] 1/1/92-30/6/92
[6] 1/3/92-30/6/92
[7] 1/7/92-31/7/92
[8] 14/5/92-31/8/92
[9] 1/7/92-31/8/92

AHS Infection	CSA	SSA	ESA[1]	SWS	WSA[2] + WEN	NSA[3]	CCA[4]	ILL[5]	HUN[6]	NCR[7]	NER[8]	OFR[9]	CWR	SWR	SER
Chlamydia trachomatis			141		29	4	3	13	8	–	6	7			
Donovanosis			–		–	–	–	–	–	–	–	–			
Genital herpes			371		27	11	3	27	29	–	6	8			
Genital warts			778		175	35	1	150	80	11	18	6			
Non-specific urethritis			501		189	18	1	53	42	–	5	1			
Lymphogranuloma Venereum			–		–	–	–	–	–	–	–	–			

For notifications received by 7 September 1992

TABLE 13

INFECTIOUS DISEASE NOTIFICATIONS BY HEALTH AREA AND REGION CUMULATIVE 1992

CONDITION	CSA	SSA	ESA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NCR	NER	OFR	CWR	SWR	SER	U/K	OTH	TOTAL
Adverse event after immunisation	3	3	–	–	1	–	–	1	–	1	5	7	–	–	1	5	–	–	27
AIDS infection	21	2	5	2	8	5	22	2	2	2	9	4	–	2	5	2	–	–	93
Arboviral infection	1	2	–	–	6	6	6	7	7	20	108	24	52	10	25	–	–	–	274
Cholera	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	1
Foodborne illness (NOS)	5	2	31	2	33	8	–	10	3	5	5	4	31	1	1	–	–	–	141
Gastroenteritis (instit)	17	1	9	1	4	1	–	–	1	50	2	94	4	–	–	–	–	–	184
Gonorrhoea infection	48	17	103	8	16	1	17	2	3	7	16	10	8	9	5	5	–	–	275
H. Influenzae epiglottitis	–	3	1	3	6	3	1	–	2	4	3	3	–	–	1	1	–	–	31
H. Influenzae meningitis	3	4	3	5	5	5	16	1	7	4	5	4	1	–	3	3	–	–	69
H. Influenzae septicaemia	–	1	1	3	2	–	3	–	–	2	1	–	–	2	1	–	–	–	16
H. Influenzae infection (NOS)	3	1	2	–	2	–	–	4	–	2	–	1	1	2	2	3	–	–	23
Hepatitis A — acute viral	82	30	103	18	38	6	76	4	21	26	85	112	45	4	7	6	–	1	667
Hepatitis B — acute viral	4	3	30	4	4	2	3	1	6	1	8	3	18	2	2	1	–	–	92
Hepatitis B — unspecified	265	267	16	174	266	24	195	21	12	83	44	34	22	13	12	19	–	2	1469
Hepatitis C — acute viral	1	1	4	14	7	1	3	1	3	–	8	5	4	3	–	1	–	–	56
Hepatitis C — unspecified	329	99	238	56	178	35	166	295	53	284	373	36	7	38	13	17	–	–	2217
Hepatitis D — unspecified	–	–	1	–	–	–	–	1	–	1	2	–	–	–	–	–	–	–	5
Hepatitis, acute viral (NOS)	–	–	1	4	1	–	–	1	–	–	–	1	3	2	1	–	–	–	14
HIV infection	48	18	140	9	23	7	30	3	2	20	16	–	3	–	1	4	180	10	514
Hydatid disease	–	–	–	–	–	–	–	–	–	–	1	2	–	1	–	–	–	–	4
Legionnaires' disease	3	2	1	36	14	2	4	7	2	2	1	–	–	–	–	1	–	–	75
Leprosy	–	–	–	1	1	1	–	–	–	–	–	1	–	–	1	–	–	–	5
Leptospirosis	–	1	–	–	–	1	–	–	–	–	5	2	–	5	–	–	–	–	14
Listeriosis	–	1	–	–	–	2	4	–	–	–	1	–	–	1	–	–	–	–	9
Malaria	10	7	7	2	13	–	17	–	6	2	6	7	1	1	4	2	–	–	85
Measles	33	11	7	15	24	8	16	6	10	49	17	13	10	5	1	7	–	–	232
Meningococcal meningitis	4	3	–	2	2	2	–	6	4	4	6	2	1	5	–	–	–	–	41
Meningococcal septicaemia	–	1	2	3	–	1	–	–	–	–	–	–	1	–	–	–	–	–	8
Meningococcal infection (NOS)	–	–	2	–	–	–	1	–	1	–	–	2	1	2	–	–	–	–	9
Mumps	–	–	3	1	3	–	1	–	1	3	1	–	–	–	1	1	–	–	15
Mycobacterial atypical	29	12	32	14	20	3	25	–	6	17	–	–	–	–	1	–	–	–	159
Mycobacterial tuberculosis	32	22	21	54	29	5	39	7	9	4	7	5	–	1	5	5	–	–	245
Mycobacterial infection (NOS)	7	5	–	–	5	2	7	1	5	3	–	4	1	–	2	–	–	1	43
Pertussis	2	9	1	6	5	5	11	3	–	6	25	2	–	–	–	–	–	–	75
Q Fever	–	–	–	–	5	2	–	1	–	6	42	22	14	2	3	2	–	–	99
Rubella	2	–	3	1	5	1	9	–	–	2	4	1	–	–	–	2	–	–	30
Salmonella (NOS)	19	26	30	21	36	22	63	13	8	22	40	20	15	15	11	15	–	–	376
Salmonella bovis morbificans	1	2	–	–	2	1	1	–	–	–	1	1	–	–	–	–	–	–	9
Salmonella typhimurium	7	16	2	9	25	17	17	3	4	13	2	2	5	–	4	–	–	–	126
Syphilis infection	101	35	96	13	31	5	29	–	8	6	88	25	81	12	4	2	–	1	537
Tetanus	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1
Typhoid and paratyphoid	4	–	6	–	3	–	5	–	1	–	–	–	–	–	2	–	–	–	21

Abbreviations used in this Bulletin:
CSA Central Sydney Health Area, SSA Southern Sydney Health Area, ESA Eastern Sydney Health Area, SWS South Western Sydney Health Area, WSA Western Sydney Health Area, WEN Wentworth Health Area, NSA Northern Sydney Health Area, CCA Central Coast Health Area, ILL Illawarra Health Area, HUN Hunter Health Area, NCR North Coast Health Region, NER New England Health Region, OFR Orana & Far West Health Region, CWR Central West Health Region, SWR South West Health Region, SER South East Health Region, OTH Interstate/Overseas, U/K Unknown, NOS Not Otherwise Stated

Please note that the data contained in this Bulletin are provisional and subject to change because of late reports or changes in case classification. Data are tabulated where possible by area of residence and by the disease onset date and not simply the date of notification or receipt of such notification.

TABLE 14

PHO EPIDEMIC LOG — 1.9.92

1990	Disease	Area	Reports	Investigators
Aug	SIDS	Coffs Harbour	Report on the occurrence of SIDS in the Coffs Harbour LGA 1 April-31 July 1990	M Frommer, C Roberts
Oct	SIDS	Western Sydney	The investigation of SIDS in Western Sydney	P Lewis
Nov	Asthma	New England	Epidemic of asthma in Tamworth	S Corbett, M Bek
Dec	Measles	Hunter	Report on a significant outbreak of measles in the Hunter Area of NSW — Epi 2 Analysis of the 1990 measles outbreak in the Hunter Area of NSW — Epi 3	T Miles, J James T Miles
1991				
Feb	Meningococcal meningitis	Newcastle	Response to meningococcal meningitis — Epi 2	T Miles, M Rea
Mar	Stillbirths	Queanbeyan	Queanbeyan cluster investigation — stillbirths and spontaneous abortions	V Westley-Wise, P Hlavacek, G Sam
May	Measles	Central & Southern Sydney	Epi 1, Epi 2, Epi 3	L Taylor
May	Gastroenteritis	Tamworth	An apparent outbreak of a gastrointestinal illness in a school	G Close, M Levy, J Rooney
Jun	Haemophilus influenzae B	Central & Southern Sydney	Epi 2	K Goldston, L Taylor
Jun	Scarlet fever	Illawarra	Investigation of a reported outbreak of scarlet fever in a day care centre	V Westley-Wise
Jul	Meningococcal disease	South Western Sydney	Meningococcal outbreak in South Western Sydney	K Chant, G Stewart, J Brown
Aug	Measles	Newcastle	Measles in Mayfield East — Epi 2	T Miles, M Rea
Aug	Measles	Maitland	Measles in East Maitland — Epi 2	T Miles, M Rea
Sep	Measles	Maitland	Measles in East Maitland — Epi 2	T Miles, M Rea
Sep	Haemophilus influenza B	Central & Southern Sydney	Epi 2	K Goldston, L Taylor
Sep	Hepatitis A	Central & Southern Sydney	Epi 2	K Goldston, L Taylor
Sep	Meningococcal septicaemia	Central & Southern Sydney	Epi 2	K Goldston, L Taylor
Oct	Haemophilus influenza B	Central & Southern Sydney	Epi 2	K Goldston, L Taylor
Oct	Haemophilus influenza B	Central & Southern Sydney	Epi 2	K Goldston, L Taylor
Oct	Cancer	Illawarra	Report of an investigation of a suspected cancer cluster in Coalcliff residents	V Westley-Wise
Nov	Gastroenteritis	Singleton	Investigation of an outbreak of gastroenteritis — Epi 3	T Miles, V Westley-Wise, M Levy
Nov	Meningococcal meningitis	Central & Southern Sydney	Epi 2	K Goldston, L Taylor
Nov	Gastroenteritis	Eastern Sydney	Investigation of an outbreak of gastroenteritis in Eastern Sydney	M Williamson, C Cowie, L Young
Nov	Salmonella typhimurium	NSW	Salmonella typhimurium phage type 9 outbreak	J Westbrook, E Kraa
Dec	Hepatitis A	Eastern Sydney	Report on hepatitis A in Eastern Sydney — Epi 3	M-L Stokes, W Manning
Dec	Scabies	Wollongong	Investigation of a scabies outbreak in a local nursing home	V Westley-Wise
Dec	Vibrio pararhaemolyticus	Central Sydney	Suspected food poisoning outbreak at an hotel	E Kraa, H Moore
1992				
Jan	Meningococcal meningitis	Central & Southern Sydney	Epi 2	K Goldston, L Taylor
Jan	Asthma	South Western Sydney	Asthma attendances at hospital and ozone	P Lewis, D Lyle, H Moore
Apr	Diarrhoea	Eastern Sydney	Diarrhoea outbreak in a day care centre	S Furber, M Ferson
Apr	Gastroenteritis	Central & Southern Sydney	Investigation of an outbreak of gastroenteritis at a day care centre, Illawong	C Lonie, K Goldston
May	Diarrhoea	Cessnock	Diarrhoea in a nursing home	P Lewis, W Stanton
Jun	Haemophilus influenza B	Randwick	A case of Hib meningitis at Randwick open care for kids	S Furber, M Ferson
Jul	Meningococcal septicaemia	Eastern Sydney	A case of meningococcaemia at the Hibiscus Children's Centre	S Furber, L Young, M Ferson
Aug	Haemophilus influenza B	Eastern Sydney	A case of Hib meningitis at Hillsdale child care centre	S Furber, L Young, M Levick, M Ferson
Aug	Legionnaires' disease	South Western Sydney	Report on Legionnaries' disease in South Western Sydney in April 1992	M Levy, V Westley-Wise, M Frommer, D Lyle, C Blumer, G Rubin, J Brown, C Salisbury-Marsh, G Stewart