INFECTIOUS DISEASES, NSW: OCTOBER 1999

TRENDS

Reports of notifiable diseases to the end of August were largely unremarkable for this time of year (Figure 2, Table 3). However, 27 cases of meningococcal disease were reported for August, part of the expected late-winter, early-spring peak for this disease.

NSW INFLUENZA SURVEILLANCE ACTIVITY UPDATE

Summary

Influenza activity reached a plateau in early September. In August, influenza A declined sharply, and influenza B emerged as the dominant strain. However, this activity has since declined. While the influenza season arrived earlier in 1999 than in the previous few years, activity has not exceeded the peaks recorded in recent years.

Clinical activity

Rates of reported influenza-like illness varied during August and early September but remained below the peak reached in early July (Figure 3). Reports were received from more than 30 sentinel general practitioners (GPs) through four Public Health Units, including more than 4,000 consultations. However, this source of data may include illness due to causes other than influenza.

Virological activity

The laboratory reporting rate for influenza A continued to decline during August and early September. Reporting of influenza B increased and peaked in mid-August (Figure 4). In the second week of September 9 cases of influenza A were reported (7 virological, 2 serological), 18 cases of influenza B (13 virological, 5 serological) and 39 of respiratory syncitical virus (RSV). In the same week last year, there were 18 cases of influenza A, no cases of influenza B and 55 cases of RSV. This data source tends to include a high proportion of hospitalised patients, particularly children, and may not accurately reflect the effect of these diseases on other sections of the community.

Directed virological surveillance

The number of samples submitted for viral examination as part of this special surveillance program decreased markedly from 34 (3 positive for influenza A, 6 for influenza B) in the first week of August to 5 (none of which were positive for any respiratory virus) in the second week of September. This probably reflects a decrease in the number of patients presenting with influenza-like illness to participating sentinel GPs. This trend is consistent with the other data sources discussed previously; that is, the influenza isolation rate has been variable during August and early September, influenza A decreased markedly in early August, and influenza B remained higher and decreased in September.

The sentinel GPs participating in the scheme this year are from Central Sydney, South Eastern Sydney, Western Sydney, Wentworth, Central Coast, Hunter, Illawarra, Greater Murray and Southern Areas.

International surveillance

Few reports of influenza were received by the World Health Organization during August. Activity in the Southern Hemisphere this winter has varied considerably between countries, but high levels have rarely been reported. New Zealand reported a decline in cases since the first two weeks of July, with more influenza A than B reported. Argentina reported influenza A activity at the level of 'widespread outbreak' for the month of July. South Africa continues to report sporadic influenza activity for the week ending 17 August, with more cases of influenza B than A; and Chile and Paraguay both reported 'sporadic' activity of influenza A.

In the Northern Hemisphere, Israel reported two cases of influenza in the last week of July, one each of influenza A and B. Brazil reported a 'local outbreak' of influenza A activity during the first week of August, Thailand reported 'sporadic activity' of influenza A from May to the end of July.

MANAGEMENT OF MULTI-DRUG-RESISTANT TUBERCULOSIS IN NSW

Australia is fortunate to have one of the world's lowest tuberculosis rates. This has been achieved and maintained by the success of the post-World War II national tuberculosis campaign; continued commitment of dedicated tuberculosis services by state and federal governments; and the worldwide downward trend in tuberculosis incidence this century.

The National Health and Medical Research Council (NH&MRC) Tuberculosis Working Party identified the main threats to the control of tuberculosis in Australia to be inappropriate or inadequate approaches to tuberculosis treatment in persons born overseas and an increase in the rate of multi-drug-resistant tuberculosis (MDR TB).[1]

MDR TB is defined as bacilli that are identified *in vitro* as resistant to at least isoniazid and rifampicin, the main drugs used to treat tuberculosis.[2] MDR TB represents an important public health concern for the effective control of tuberculosis.

The development of drug-resistant bacilli relate directly to error in the:[2]

- prescription of chemotherapy
- management of drug supply
- inappropriate management of cases
- ineffective administration of drugs to the patient.

continued on page 143

FIGURE 2

REPORTS OF SELECTED INFECTIOUS DISEASES, NSW, JANUARY 1994 TO AUGUST 1999, BY MONTH OF ONSET

These are preliminary data: case counts in recent months may increase because of reporting delays

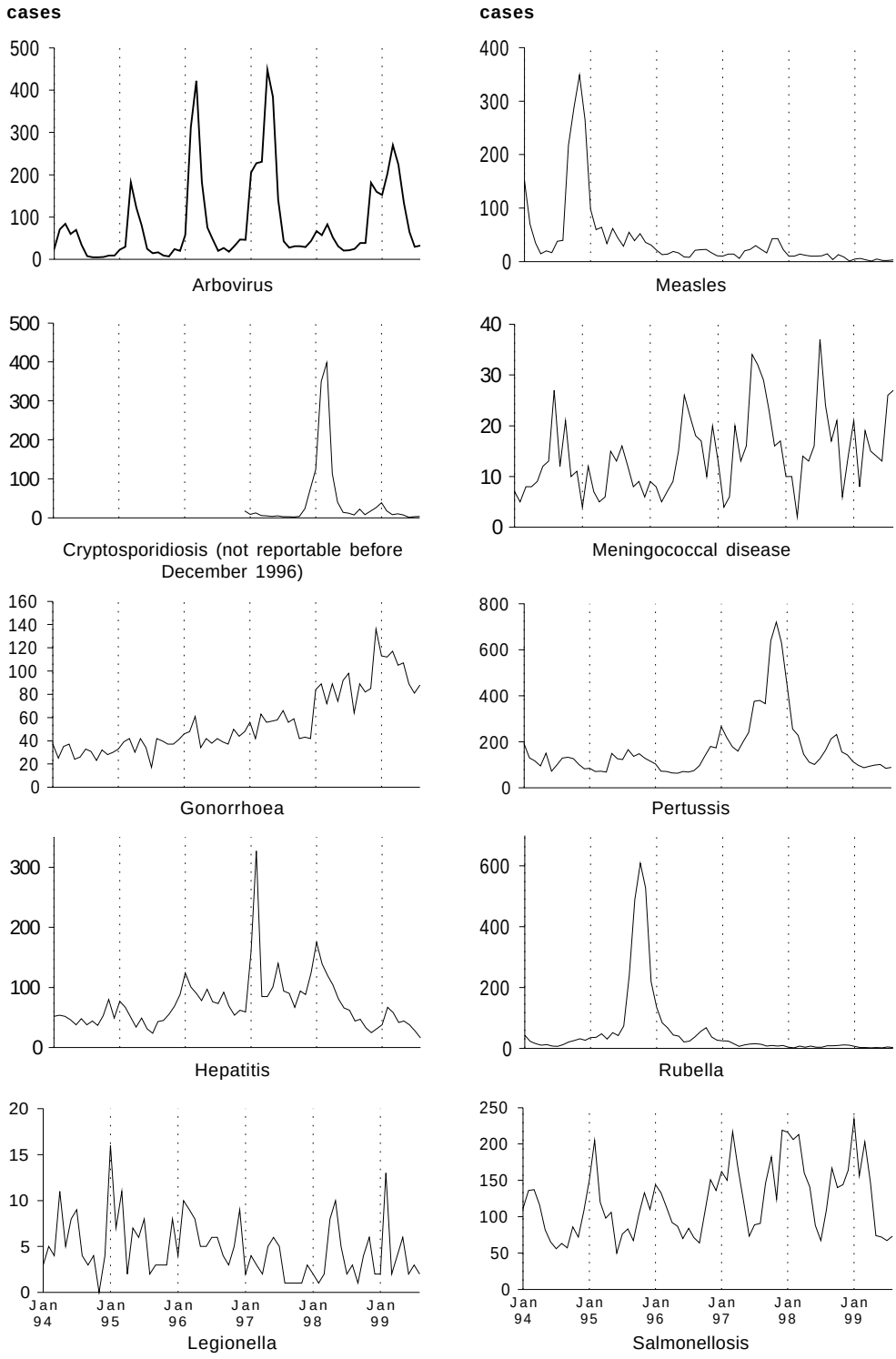


TABLE 3 REPORTS OF NOTIFIABLE CONDITIONS RECEIVED IN AUGUST 1999 BY AREA HEALTH SERVICES

Condition	Area Health Service (1999) CSA	NSA	WSA	WEN	SWS	CCA	HUN	ILL	SES	NRA	MNC	NEA	MAC	MWA	FWA	GMA	SA	Total for Aug†	Total To date†
Blood-borne and sexually transmitted																			
AIDS	–	–	–	–	–	–	3	–	3	1	7	–	–	–	–	–	–	15	95
HIV infection*	–	–	Reported every two months				–	–	–	–	–	–	–	–	–	–	–	–	194
Hepatitis B: acute viral*	1	–	2	1	–	–	–	–	1	1	–	1	–	–	–	2	–	9	43
Hepatitis B: other*	71	41	–	7	2	4	4	9	64	4	1	4	1	–	3	3	1	120	2,176
Hepatitis C: acute viral*	–	–	–	1	–	–	1	3	–	1	1	–	–	–	1	–	–	8	37
Hepatitis C: other*	78	54	13	40	2	48	56	24	99	43	47	22	4	27	6	17	34	621	5,173
Hepatitis D: unspecified*	–	–	1	–	–	–	–	–	–	1	–	–	–	–	–	–	–	2	10
Hepatitis, acute viral (not otherwise specified)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Chancroid*	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1
Chlamydia (genital)*	15	2	–	5	1	10	19	8	58	12	8	15	4	11	16	7	2	194	1,510
Gonorrhoea*	20	5	–	4	–	1	1	2	51	2	–	5	2	1	5	–	2	102	851
Syphilis	16	2	–	1	–	–	–	4	9	3	2	2	4	3	3	–	–	52	403
Vector-borne																			
Arboviral infection (BFV)*	–	1	–	–	–	–	–	3	–	3	7	–	–	–	1	1	–	16	208
Arboviral infection (RRV)*	1	–	1	–	1	1	2	4	–	4	2	–	1	–	4	1	1	23	1,006
Arboviral infection (Other)*	–	2	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	3	14
Malaria*	3	9	2	–	1	2	1	–	5	2	3	–	1	–	–	1	–	30	137
Zoonoses																			
Brucellosis*	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	3
Leptospirosis*	–	–	–	–	–	–	–	–	–	1	–	1	1	–	–	–	–	3	34
Q fever*	–	–	–	–	–	–	2	–	1	1	2	–	1	–	1	–	4	12	98
Respiratory and other																			
Blood lead level*	6	2	–	–	3	1	6	8	1	–	–	2	–	–	68	1	–	99	462
Legionnaires' Longbeachae*	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	10
Legionnaires' Pneumophila*	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	1	–	2	20
Legionnaires' (Other)*	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	5
Leprosy	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Meningococcal infection (invasive)	–	2	3	5	5	–	–	3	–	1	3	1	1	3	–	–	–	27	140
Mycobacterial tuberculosis	5	5	9	–	–	1	3	1	7	1	–	–	2	–	–	–	2	38	270
Mycobacteria other than TB	1	2	–	1	–	1	5	1	2	2	1	–	–	–	–	1	2	19	269
Vaccine-preventable																			
Adverse event after immunisation	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	21
H. influenzae b infection (invasive)*	–	–	–	1	–	–	–	–	1	–	–	–	–	–	–	–	–	2	9
Measles	–	–	–	–	–	–	–	2	–	–	–	–	–	–	–	–	1	3	27
Mumps*	1	1	–	–	–	–	–	–	1	–	1	–	–	–	–	–	–	4	18
Pertussis	8	14	5	5	9	5	29	5	9	1	5	1	2	2	–	7	3	110	840
Rubella*	–	2	–	–	1	–	–	–	1	1	–	–	–	–	–	–	–	5	28
Tetanus	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Faecal-oral																			
Botulism	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Cholera*	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2
Cryptosporidiosis*	–	–	–	–	–	–	–	–	1	2	–	–	–	–	–	–	–	3	103
Giardiasis*	7	12	–	3	–	5	12	2	15	5	1	2	3	2	4	1	–	74	768
Food-borne illness (not otherwise specified)	–	–	–	–	–	–	–	–	1	–	–	–	–	3	–	–	–	4	23
Gastroenteritis (in an institution)	16	–	–	–	–	–	–	7	–	–	–	–	9	–	–	–	–	32	251
Haemolytic uraemic syndrome	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	8
Hepatitis A*	4	–	16	1	–	1	–	–	4	1	–	–	–	–	1	–	–	28	341
Hepatitis E*	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	5
Listeriosis*	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	11
Salmonellosis (not otherwise specified)*	6	8	5	1	3	3	12	7	9	10	–	3	–	–	1	2	–	75	1,098
Typhoid and paratyphoid*	1	–	–	–	1	–	–	–	1	–	–	–	–	–	–	–	–	3	23
Verotoxin producing *E. coli**	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

* lab-confirmed cases only

† includes cases with unknown postcode

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

FIGURE 3

NSW GP SENTINEL SURVEILLANCE—INFLUENZA-LIKE ILLNESS, BY WEEK OF CONSULTATION, WITH HISTORICAL COMPARISONS

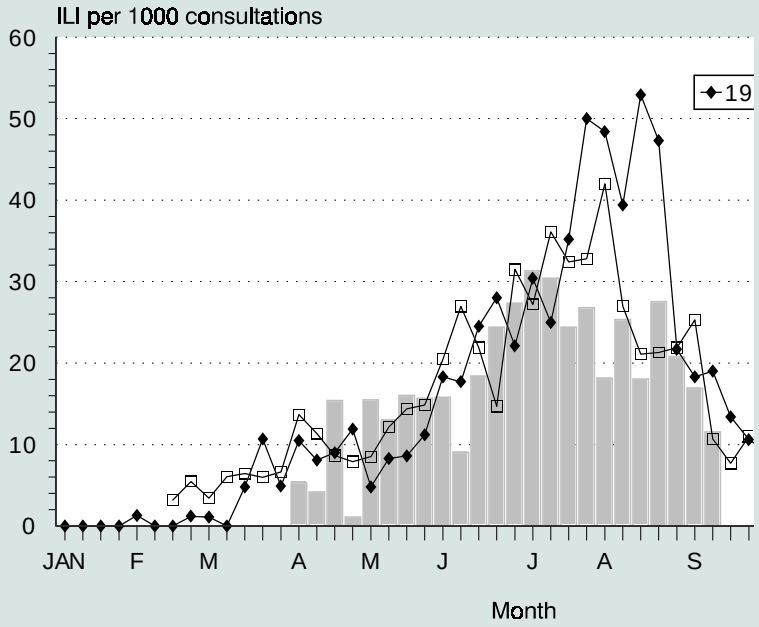
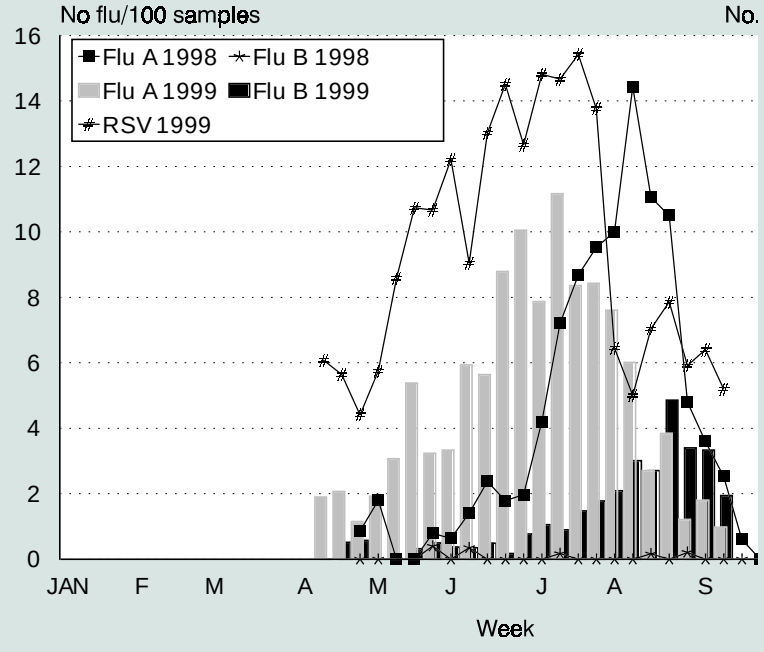


FIGURE 4

RESPIRATORY VIRUS ISOLATION RATES, NSW, 1990–1999



continued from page 139

To ensure that there is not an increase in the incidence of MDR TB and to promote best-practice management of MDR TB, an expert panel will be convened to review all cases identified as MDR TB in NSW. The panel will develop a case-management plan and will report to the Chief Health Officer.

Referring MDR TB cases

Cases can be directly referred to the panel via the State Tuberculosis Coordinator on receipt of bacteriological culture and sensitivity reports. The State Tuberculosis Coordinator can be contacted on (02) 9391 9277 at the NSW Department of Health.

In addition, clinicians can refer 'difficult to manage' cases of active tuberculosis to the panel for peer review and discussion. Once again, referral to the panel can be made via the State Tuberculosis Coordinator.

The MDR TB panel

The recommended composition of the panel includes:

- the attending physician and Area Tuberculosis Coordinator
- an infectious diseases physician
- a representative from the Institute of Clinical Pathology and Medical Research
- another physician expert in tuberculosis nominated by the Chief Health Officer
- a public health practitioner
- a NSW Health Department representative
- other relevant persons as defined by the panel chair.

To maintain Australia's excellent position in controlling tuberculosis, continuing improvements are needed in program management, disease surveillance and consistent control strategies, both within and between states.

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2. Crofton J, Chaulet P, Maher D. Guidelines for the management of drug-resistant tuberculosis. Geneva: World Health Organization Global Tuberculosis Program, 1997.

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Submission of articles

Articles, news and comments should be 1000 words or less in length and include a summary of the key points to be made in the first paragraph. References should be set out in the Vancouver style, described in the *New England Journal of Medicine*, 1997; 336: 309–315. Send submitted articles on paper and in electronic form, either on disc (Word for Windows is preferred), or by email. The article must be accompanied by a letter signed by all authors. Full instructions for authors are available on request from the editor.

Editorial correspondence

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