KEEPING TABS ON TOXIC SUBSTANCES

In the past 20 years public interest in the effects of workplace and environmental exposures to hazardous chemicals has grown, as a result of intense investigative work on toxicants such as heavy metals, fungi, solvents and pesticides. As people seek greater assurances about the safety of chemicals and demand firmer controls over their use, the Toxicology Unit of the NSW Health Department is fulfilling an important and growing monitoring role.

Concern also has been generated by the fact that cancer is induced by some chemicals, by issues being aired in the courts (as in the case of Agent Orange), by media coverage of public health issues and by preventive health educational programs.

The Health Department set up its Environmental Toxicology Unit in 1988. Toxicology, the study of poisons and their effects in living organisms, may be divided into several areas — clinical, forensic, environmental and others. Environmental toxicology is mainly concerned with the acute and chronic toxic effects of domestic, industrial and agricultural chemicals in food, soil, water and air.

The International Agency for Research on Cancer and other authorities have listed suggested and proven carcinogenic substances, and the report of the United States Toxic Substances Strategy Committee to President Carter in May 1980 catalogued a number of other effects of hazardous chemicals on humans. They included birth defects and other reproductive anomalies, kidney and liver damage, neurological and behavioural disorders, lung and chest diseases, acute poisoning and acute and chronic skin disease.

The Commonwealth Standing Committee on Environment and Conservation presented its second report on the Inquiry into Hazardous Chemicals (Australian Government Publishing Service) in 1982. The purpose of the inquiry was to examine legislative and administrative mechanisms and make recommendations to ensure that all chemicals are properly assessed, hazards made known and appropriate regulatory controls implemented (the first report dealt with the storage, transport and disposal of hazardous chemical wastes).

In 1990 the NSW Government instigated its own inquiry into the manufacture, transport, storage and disposal of chemicals as a result of the Diversey factory fire at Seven Hills, Sydney, in December 1989. Its scope was extended after the Boral Ltd LPG depot explosion and fire at St Peters, Sydney, in April 1990.

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Keeping Tabs on Toxic Substances

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Reports from many sources on particular aspects of damage and suspected damage to humans by chemicals continue to be received by the Health Department and other authorities and there have been many expressions of public concern over the use and safety of agricultural, veterinary, manufacturing and household chemicals.

CONTROL OF HAZARDOUS CHEMICALS IN NSW

Legislation is extensive and complicated and involves international bodies, Australian, State and local authorities. Because agricultural, industrial, domestic and other substances of toxic nature can be numbered in the tens of thousands throughout the world, NSW and Australia rely on an established system for the protection of the population for pharmaceuticals and pesticides. Industrial chemicals are now controlled by a new legislative system, the National Chemicals Notification and Assessment Scheme, administered by Worksafe Australia.

The Australian Agricultural and Veterinary Chemicals Act provides national legislation for the evaluation and clearance of agricultural and veterinary chemicals to be registered for particular uses in the States and Territories. The Act establishes an Australian Agricultural and Veterinary Chemicals Council, which co-ordinates the evaluation of chemicals proposed for registration in Australia and grants certificates of clearance for chemicals whose safety and effectiveness have been demonstrated to its satisfaction.

The council evaluates detailed submissions which provide information on formulation, stability, proposed use, efficacy, safety, toxicology (including acute and chronic studies) and residue levels. Many other matters are also reviewed.

Once an agricultural chemical or veterinary drug is cleared by the Australian Agricultural and Veterinary Chemicals Council, it usually is registered automatically in each State and Territory. In NSW this is done under the Agricultural Acts and in some cases under the Poisons Act.

One of the chief objectives of classification in the Poisons Act is to ensure the product is adequately packaged and labelled, including the declaration of the active ingredients and their proportions, the provision of safety directions (to minimise hazard to the user), directions for use (to maximise efficacy and safety) and directions for first aid attention (in case unintentional poisoning occurs).

When new data on toxicity become available for chemicals which have been registered and in use for some time, they are reviewed by the same system. Such data are received from manufacturers, from other organisations and from government sources. The assessment and control of therapeutic drugs is by similar Commonwealth (through the National Health and Medical Research Council) State procedures.

THE ROLE OF THE NSW HEALTH DEPARTMENT

The legislative involvement of the State's Health Department in the control of hazardous chemicals, with the exception of the Poisons Act and the Therapeutic Goods and Cosmetics Act, is minimal. Nevertheless, the final considerations in many cases of environmental pollution are the effects — present and future — of human exposure. Other authorities and the public expect that the Health Department should be able to provide both expert information and assistance and that it is equipped to do so. This was the reason for setting up the Toxicology Unit, with these functions:

- To advise the Department on regulatory procedure for hazardous chemicals.
- To collect world data and assess the hazards likely to arise from exposure to chemicals and other agents.
- Maintain departmental contact and co-ordinate toxicological activities with other agencies such as the NH&MRC, Worksafe Australia, WorkCover Authority, State Pollution Control Commission and Agriculture and Fisheries.
- To support toxicological research and training.
- The establishment of a departmental pesticides committee which advises the Deputy Chief Health Officer on pesticides and other agricultural chemicals which may influence human health.
- To initiate investigations and recommend actions necessary to protect the public from harm from hazardous chemicals and other agents.
- To provide expert advice and assistance to Regional Offices of Health, Area Health Services and Public Health Units.

The Toxicology Unit is very small and for information and assistance it uses an existing network. Many people in the network are conversant with their counterparts in the different organisations.

The Unit welcomes requests from PHUs on toxicological matters and has issued guidance notes to help PHUs prepare toxicological profiles of their Areas and Regions. The profiles will assist in anticipating possible accidental discharges and concerns of the public on health-related issues such as contaminated land, incineration, water supplies and residues in food.

David Fox
Toxicology Unit
NSW Health Department

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WHERE TO GET HELP

Sources from which information can be obtained on toxicity and other chemical matters:

To provide regulatory and technical advice on public health aspects of chemical usage:
- Toxicology Unit
  Public Health Services
  NSW Health Department
  Macquarie Hospital, Wicks Road
  NORTH RYDE NSW 2113
  Director: Dr D Fox
  Ph: (02) 887-5600
- Pesticides Committee (Health Department)
  Secretary: Mr G Richards
  Ph: (02) 887-5605

For assistance and clarification on the Poisons Act, pharmaceuticals and other therapeutic goods:
- Duty Pharmacist
  Pharmaceutical Services Section
  Public Health Services
  NSW Health Department
  Macquarie Hospital, Wicks Road
  NORTH RYDE NSW 2113
  Ph: (02) 887-5617

For information on chemical additives and residues in foodstuffs:
- Food Inspection Branch
  Public Health Services
  NSW Health Department
  Macquarie Hospital, Wicks Road
  NORTH RYDE NSW 2113
  Ph: (02) 887-5617

Advice on treatment of poisonings:
- Poisons Information Centre
  Royal Alexandra Hospital for Children
  Pyrmont Bridge Road
  CAMPERDOWN NSW 2050
  24-hour telephone service:
  (02) 519-0466 hospital
  (02) 692-6111 direct
  (008) 251 525 toll free — outside Sydney
- Division of Analytical Laboratories
  NSW Health Department
  Joseph Street
  LIDCOMBE NSW 2141
  Director: Dr E Crematy
  Ph: (02) 646-0222

For information on ionising and non-ionising radiation:
- Radiation Services Branch
  NSW Health Department
  Joseph Street
  LIDCOMBE NSW 2141
  OIC: Mr A Fleischmann
  Ph: (02) 646-0222

For advice on cancer statistics and cancer epidemiology:
- Central Cancer Registry
  NSW State Cancer Council
  Macquarie Hospital
  Wicks Road
  NORTH RYDE NSW 2113
  Ph: (02) 887-5637
  (02) 887-5638

For information on environmental matters including air, soil and water standards:
- State Pollution Control Commission
  Civic Tower
  Jacobs Street and Rickard Road
  BANKSTOWN NSW 2200
  Ph: (02) 793-0000

For information on disposal of toxic and other waste:
- Waste Management Authority of NSW
  Zenith Centre
  821 Pacific Highway
  CHATS WOOD NSW 2067
  Ph: (02) 412-1388

For details of pesticide registration and usage:
- NSW Agriculture and Fisheries
  McKell Building
  Rawson Place
  SYDNEY NSW 2000
  Registrar of Agricultural and Veterinary Chemicals: Mr R Toffolon
  Ph: (02) 217-5475

For assistance with occupational hazards and incidents:
- WorkCover Authority of NSW
  Division of Occupational Health
  Joseph Street
  LIDCOMBE NSW 2141
  Ph: (02) 646-0222
- NSW Fire Brigade
  DATACHEM (A computerised information data bank on hazardous chemicals for use by Emergency Services)
  Ph: (02) 319-7000

Many of these agencies have regional representatives who can assist PHUs.

For after-hours emergency numbers each PHU should have these documents:
1. The Chemical Incident Protocol of the NSW Health Department.
3. The NSW Multiple Casualty, Emergency and Disaster Medical Response Plan (MEDPLAN).
Aboriginality is poorly recorded in the three Statewide health data collections in NSW — mortality, hospital inpatient and midwives — that routinely provide the main information on deaths. The major problem, according to Gray and Hogg, is under-enumeration. They found that 33 per cent of the 315 deaths of Aboriginal people identified in a study in rural NSW had not been coded as such in official births, deaths and marriages records.

**ABORIGINAL MORTALITY DATABASE**

The most accurate information about Aboriginal mortality has come from individual studies of specific communities. Recent studies have documented the persistently poor health status of Aboriginal Australians compared to the non-Aboriginal population (for example, Khalidi, 1989). Such studies tend to be time-consuming and resource-intensive. They deal with specific (usually geographically) defined populations and relate to deaths over an earlier, rather than current time.

As a result of their 1989 study, Gray and Hogg made several recommendations for improving the data on Aboriginal mortality in NSW. Their report was released as public health was being strengthened in NSW, including the establishment of an Epidemiology Branch within the Health Department which undertook to improve the enumeration of Aboriginal mortality in NSW.

We found that Aboriginal health workers in rural areas of NSW were already using a special form to notify the deaths of Aboriginal people to the Aboriginal Health Unit of the Health Department, thus providing a continuing but under-utilised source of data not readily available elsewhere. Aboriginal health workers at all levels were keen to retain the existing reporting system, with some modifications. The form was revised in consultation with the Aboriginal health workers and now records date of death, age at death, where the person died, where the person lived, sex, main cause of death, contributing conditions, whether there was an accident or violence involved (the latter three coded by ICD-9).

Copies of the form (minus identity) are forwarded to the Epidemiology Branch and will be used to prepare regular statistical statements on Aboriginal mortality. The new reporting system will cover deaths from October 1, 1990. The objectives of the enhanced reporting system are to improve the enumeration of Aboriginal deaths, provide Aboriginal health workers with a regular statement about deaths in their area and promote the health concerns of Aboriginal people.

The first instance the collection is unlikely to be complete: it will include only deaths of which the health workers are aware and forms will be returned only from areas where there are State health workers. We anticipate that deaths in urban Aboriginal communities will be under-represented on the register, but we plan to tackle this problem by approaching other Aboriginal health services to participate in the reporting system. Future work will concentrate on other issues central to setting up a death reporting system, including defining denominator populations, validation of death data, and cross-referencing the collection with births, deaths and marriages data.

Judith K. Jones and David Lyle, Epidemiology and Health Services Evaluation Branch, and Liz Williams, Aboriginal Health Unit, NSW Health Department.

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**KEEPING TABS ON TOXIC SUBSTANCES**

*Continued from page 18*

**EDITORIAL COMMENT**

Assessment and management of the risks posed by community exposures to any of the estimated 65,000 chemicals in industrial and domestic use in Australia is very complex. Comprehensive toxicological information is available for only a minority of the chemicals. Increasingly, the desires of "modern, literate and socially enfranchised communities to take greater control of their own social environment and health" lead to questioning of the assumptions underlying risk assessment and risk management practices. Toxicology is the fundamental science which informs these debates.

Regulatory toxicology, the branch of this science practised by the Toxicology Unit in the NSW Health Department, will face several critical issues in the coming decade. The role of quantitative risk assessment in the management of environmental health issues and the effectiveness of risk communication are two examples. Also, developments within the public health infrastructure will enable the Unit to participate in ad hoc studies in environmental health and in the analysis and interpretation of routinely collected cancer and birth defects data.

1. McMichael T Social Justice and World Health in Touch 7-4, pp 3
One of the goals of the Better Health Commission is to increase protection against and reduce exposure to environmental hazards posing a threat to health. By the year 2000 it is hoped to reduce by 10 per cent deaths and injuries caused at home by hazardous chemicals. With this in mind the Western Sector Public Health Unit decided to review some aspects of unintentional poisonings in its area.

This report summarises the separations in 1988-89 as a result of unintentional poisoning in the Western Sydney Area Health Service (WSAHS) and the Wentworth Area Health Service (WAHS). Poisonings as acts of attempted suicide are not included.

Information was obtained for all separations in the E code categories E850-E858 and E860-869 (International Classification of Diseases, Ninth Edition). The E code allows the classification of environmental events, circumstances and conditions as the cause of injury, poisoning, and other adverse effects.

Unintentional poisoning by drugs, medicinal substances and biologicals (E850-E858) include unintentional overdose of drug, wrong drug given or taken in error, and a drug taken inadvertently. These substances were grouped together for the purposes of analysis.

The E codes 860-869 include unintentional poisoning by other solid and liquid substances, gases and vapours. Appendix 1 lists the relevant E codes.

For each separation, information was obtained on age, sex, place of occurrence, number of bed days and average length of stay. The data were obtained from the Information Services Branch of the NSW Health Department.

Overall, in WSAHS and WAHS in 1988-89, total separations because of unintentional poisonings accounted for about 7 per cent of all separations due to accidents and injuries (WSAHS: n=711; WAHS: n=347). Separations by E code, age-group, sex and place of occurrence were similar for the two health areas.

Just over 85 per cent of all unintentional poisonings were from drugs and medicinal substances (Figure 1), the majority of which were prescription drugs. Anti-rheumatics, analgesics, antipyretics and the tranquillisers were the most commonly implicated drugs. Other classes of substances were each implicated in only 2-3 per cent, or fewer, of all separations due to unintentional poisoning.

The majority of the poisonings occurred in the 15- to 34-year group, with a smaller peak in the 1- to 4-year group.

FIGURE 1
UNINTENTIONAL POISONING 1988/89
SEPARATION BY E CODE

<table>
<thead>
<tr>
<th>E Code</th>
<th>WSAHS</th>
<th>WAHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>850</td>
<td></td>
<td></td>
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<tr>
<td>860-869</td>
<td></td>
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</tbody>
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WSAHS — WESTERN SYDNEY AREA HEALTH SERVICE
WAHS — WENTWORTH AREA HEALTH SERVICE

Continued on page 22 🎧
Use of gamma benzene hexachloride (Lindane) for the treatment of head lice has been under discussion, but the director of the NSW Health Department's Toxicology Unit, Dr David Fox, has given an assurance that if used as intended the preparation is safe. He has sent this letter to all health areas and regions:

"The use of gamma benzene hexachloride (Lindane) for the treatment of head lice has been questioned.

The two main preparations used for this purpose have been Quellada and Lorexane and both are listed in Schedule 2 of the Poisons Act. This limits the concentration of Lindane to 2 per cent or less and its sale for the treatment of head lice is restricted to pharmacists and medical practitioners. It may also be sold by Poisons Licence holders, namely retail stores at least 20 km from the nearest pharmacy.

Preparations of greater strength are Schedule 4 items, available only on doctor's prescription.

Quellada contains 1 per cent Lindane and Lorexane 0.2 per cent. For each preparation the recommended dose is 25 ml per treatment. Repeat treatment in eight days is recommended for Lorexane. A second application of Quellada is said to be seldom required.

The use of Lindane was discussed recently at the Drugs and Poisons Scheduling Committee of the National Health and Medical Research Council (NH&MRC), which recommended retention of Lindane in Schedule 2.

A recent communication from the NH&MRC stated that absorption of Lindane through human skin is reported to be a maximum of 9.3 per cent of the applied dose and that there is little danger of accumulation as it has properties dissimilar to some other persistent organochlorines.

The NH&MRC also informs that published information on animal studies shows that Lindane is extensively metabolised and rapidly excreted. Even when fed continuously it does not significantly accumulate in the body. It was also indicated that most purchasers of head lice products seek advice from pharmacists who do not recommend prophylactic use.

Most therapeutic agents have the potential to cause adverse effects if abused, and misuse is difficult to regulate. Lindane is no exception, but used as intended for head lice, it is safe."
**PUBLIC HEALTH ABSTRACTS**

**BCG VACCINATION NOT COST-EFFECTIVE**
For 40 years one of the main planks of the public health strategy against tuberculosis in many countries has been BCG vaccination for tuberculin negative schoolchildren. The risk of infection from tuberculosis now depends more on higher living standards and effective treatment rather than on vaccination. Evidence from a number of countries where routine BCG vaccination has been stopped strongly support the view that routine vaccination is no longer cost-effective and can be stopped. (Routine BCG is not carried out in most parts of Australia at the present time. This evidence confirms the correctness of that decision — reviewer.)


**SOCIO-ECONOMIC CONDITIONS IN CHILDHOOD**
Low socio-economic status is associated with increased risk for many health outcomes, including ischaemic heart disease. The reasons for these associations are not fully understood. A Finnish-based study has demonstrated that low socio-economic status in childhood is associated with a higher prevalence of ischaemic heart disease in middle age. Levels of risk factors measured at middle age did not account for this association. Although there is no hard evidence, it does appear that lifestyle factors in childhood predispose people to adult ischaemic heart disease.


**CAFFEINE INCREASES RISK OF HIP FRACTURE**
Caffeine increases urinary calcium output and has been implicated as a risk factor for osteoporosis. As part of the famous Framingham study, a large number of individuals were followed up with respect to caffeine intake (either as coffee or tea) and risk of fracture. Overall the intake of greater than two cups of coffee a day or four cups of tea increased the risk of hip fracture. There was no increase in risk with the intake equivalent of one cup of coffee a day.

Since caffeine use may be associated with other behaviours that are risk factors for fracture, the association may be an indirect one. Accordingly, no policy guidelines should be developed from this preliminary study.


**PHYSICAL ACTIVITY HELPS**
Evidence for an independent role of increased physical activity in the primary prevention of coronary heart disease has grown in recent years. A review of all the published studies conducted over many years has shown that the relative risk of death from coronary heart disease was 1.9 for sedentary compared with active occupations. The methodologically stronger studies tended to show a larger benefit of physical activity than less well designed studies.


**X-RAY MAMMOGRAPHY-POSITIVE RESULTS**
First results are available from a pilot x-ray mammography screening project that has been conducted in the Central Sydney Area since 1987. The overall detection rate was seven cancers per 1000 women screened. Sixty per cent of the cancers were impalpable to the examining surgeon. These results compare well with those of the major European screening studies which have concluded that such screening programs can reduce mortality from breast cancer by about 30 per cent.


**TUBERCULOSIS STILL A PROBLEM IN AUSTRALIA**
In 1986-89 new cases of tuberculosis were notified in NSW. The majority of these patients had pulmonary disease. The highest rates of infection were in people migrating from South-East Asian countries. While the current rate of 5.2 cases per 100,000 of the population is substantially less than the 57 per 100,000 in 1948, tuberculosis remains an important and serious condition in our community.


**CHILD SEXUAL ABUSE**
There is a huge gap in what people of good intent are talking about when they try to plan a system to protect sexually abused children. At one extreme is the child victim of a stranger. At the other is incest. The two are completely different. In the case of the stranger there is no dispute, the offender is at fault and must be caught.

With incest, the most appropriate program appears to be those along the lines adopted in Santa Clara in California. The aim is to stop the offence from continuing in the immediate future and to stop the addiction of the offender. This is done by rapid pre-trial diversion of the offender into a program. The diversion permits the offender to confess without going to prison, allows speed so the abuse is stopped immediately because the offender leaves the home. The child does not leave.

This Santa Clara program for father/daughter incest has been BCG vaccination for tuberculin negative schoolchildren. The risk of infection from tuberculosis now depends more on higher living standards and effective treatment rather than on vaccination. Evidence from a number of countries where routine BCG vaccination has been stopped strongly support the view that routine vaccination is no longer cost-effective and can be stopped. (Routine BCG is not carried out in most parts of Australia at the present time. This evidence confirms the correctness of that decision — reviewer.)


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HOW MEN CAN LIVE LONGER

Sports demanding prolonged vigorous physical exercise are increasingly popular. Cities all over the world take pride in organising marathons every year and millions of people exert themselves to participate in these events. A major study in Holland has compared the long-term survival of a group of athletes who were capable of participating in major ice-skating tours. They have shown that men who remain capable over many years of participating in such races have a substantially lower risk of early death. It is of interest that if the exercise is recreational it is a particular indicator of longevity.

ANIMAL FAT DIET AND COLON CANCER

Nutritional factors have been strongly suspected of being important as causes of colon cancer. In western countries the rates of the disease are up to 10 times those of many eastern and developing nations. A large prospective study conducted among more than 38,000 middle-aged US women has shown that an intake of animal fat is positively associated with the risk of colon cancer. A low intake of fibre from fruits appears to contribute to the risk of colon cancer.

This study provides evidence for the hypothesis that a high intake of animal fat increases the risk of colon cancer and supports existing recommendations to substitute fish and chicken for meats high in fat.

TANNING WITH ULTRAVIOLET SUNBEDS SHOULD BE DISCOURAGED

A review of the studies conducted on this issue has strongly suggested that such exposure may be harmful. The problems include increased skin fragility and blistering and a slight increase in the risk of inducing melanoma. Accordingly, their use should be discouraged at all: children, people who burn easily and do not tan, and there are several groups which should not use them at all: children, people who burn easily and do not tan, and those with a history of skin cancer.

WEIGHT CONTROL SUCCESS

A new paper in the Community Health Studies describes the successful experience on the North Coast of NSW in the recruitment, training and supervision of community educators for weight control programs. The programs appear to be effective and they also provide sound satisfaction for the group leaders. (Similar widespread experiences exist in Sydney with the weight control programs conducted in a similar fashion. These were established by Norma Dembecki in the early 1970s and preceded the now familiar commercial programs — editor.)

How Men Can Live Longer

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SEVERE MEASLES AND VITAMIN A

Measles remains a devastating disease for which specific therapy is lacking. Hopes for its control rest on immunisation, but measles kills about 2 million children each year and cripples an untold number through blindness and lung disease. The disease is most devastating in developing countries where children have poor nutritional levels.

The idea that vitamin A may have a protective effect in measles was suggested more than 50 years ago but recent trials have confirmed its value. That vitamin A should be of benefit in measles is biologically plausible because measles depresses serum levels of vitamin A and vitamin A is known as an anti-infective vitamin, a conclusion based on many studies.

A new randomised double blind trial in South Africa has shown that treatment with vitamin A reduces morbidity and mortality in measles and a recommendation has been made that all children with severe measles should be given vitamin A supplements whether or not they are thought to have a nutritional deficiency.

STRESS IN WOMEN JUNIOR HOUSE OFFICERS

A British study has shown that while both male and female junior house officers may be stressed, there are particular problems for the women. Overwork was perceived as creating the most difficulty followed by effects on personal life, serious failures of treatment and talking to distressed relatives. Six sex-related sources of stress were identified, seven between career and personal life (this was the major problem), and to a much lesser degree sexual harassment at work, lack of female role models and prejudice from some patients.

The author has recommended that as 50 per cent of medical graduates are female, substantial changes need to be made in the career paths of women doctors.

Public Health Abstracts

Continued from page 24

**FAMILY HISTORY REQUIRES EARLY SURVEILLANCE**

Several new studies from the United States have shown that some forms of breast cancer are familial. Where the onset of breast cancer occurs at a young age the risk in relatives is substantially increased. Accordingly, for such individuals an intensive surveillance program is required which includes an annual breast examination by a physician and at age 25 they should begin annual mammographic screening.


**SEVERE HEAT STROKE IN AN EXPERIENCED ATHLETE**

In spite of many warnings severe environmental heat injury continues to occur. In early 1988 a 28-year-old athlete ran in an Australian ‘fun run’ when the temperature was 31 degrees and humidity 40 per cent. (These are both relatively high.) He led the race until 0.5km from the finish when he collapsed. He suffered extreme heat stroke with severe damage to many body systems including the nervous system. Muscle breakdown meant he required a hind-quarter amputation of one leg. After five months in intensive care he slowly recovered and was able to return to work.

This distressing example again indicates the need for athletes to be thoroughly acclimatized, to run in the cool time of the day or year and for officials to force athletes suspected of having heat stroke to stop for immediate treatment.


**COLORECTAL CANCER — WE ARE NOT READY FOR MASS SCREENING**

The epidemiology of colorectal cancer appears to favour screening. But a review of the costs, practicality and dangers of screening programs has demonstrated that despite increasing interest, such a program is not appropriate at present. Australia should await the results of major overseas trials which will become available in three to five years before proceeding with mass screening.


**FEWER SPERM IN SUMMER**

Demographers have repeatedly noted reductions in the birth rate during the summer. This is similar to several warm climates. This phenomenon may account, at least in part, for the reduction in the birth rate during spring in regions with warm climates. The reason for this is not the heat of the summer. Other factors may include increased exposure to light during the summer. This is similar to several other animal species. These studies are relevant to the need to increase fertility in men with fertility problems.


**FLUORIDATION — DOWN BUT NOT OUT**

In recent years studies have challenged a long-standing belief that fluoridation is responsible for large reductions in dental decay in the past three decades. The latest review is by John Colquhoun from New Zealand.

He challenges the methodology of Dean’s work in the United States, which formed the basis for the widespread introduction of fluoride to water supplies in many countries. He also refers to the range of papers by Diesendorf, a Canberra-based researcher who has long challenged the value of fluoridation.


**PESTICIDES IN BREAST MILK**

Pesticides have been widely used in agriculture to enhance food production, and pesticide residues are found in most human breast milk samples taken in industrial countries. A new survey from Victoria has confirmed this, but has also shown there has been a decline in the content of pesticides in human breast milk in the past 15 years with the important exception of dieldrin which has remained low, but similar since 1970-71.

Although there is no difficulty in agreeing that exposure to high levels of pesticides can cause acute toxicities and even death, their effect at low levels is unclear. Doll and Peto, in their authoritative book *The Causes of Cancer*, examined the causes of all cancers and concluded that the occurrence of pesticides as dietary pollutants seems unimportant.

But the matter needs to be kept under review, particularly with the introduction of new pesticides on a regular basis.


**COFFEE, CAFFEINE AND CARDIO-VASCULAR DISEASE IN MEN**

For many years an association has been suspected between coffee drinking and cardio-vascular disease, but studies have been inconsistent. It is known that coffee may raise serum cholesterol levels, although this effect is probably influenced by the brewing method. In a large American trial involving more than 46,000 men, it has been shown that coffee and caffeine consumption does not increase the risk of coronary heart disease or stroke.

This is not in accord with a recent Scandinavian study which has shown that boiled coffee does raise the blood serum cholesterol levels, probably because boiled coffee leeches out the lipids from the coffee beans—editor.

The tabulations of notified diseases have been altered slightly in three respects — (i) Central Sydney and Southern Sydney are now listed consecutively, (ii) interstate (US) and overseas (O/S) are combined as “OTH”, and (iii) Mycobacterial disease (Not Otherwise Stated) appears instead of tuberculosis as this entry relates to presumptive diagnoses of tuberculosis which contain a proportion of atypical mycobacteria. Leprosy continues to be listed separately.

The lower number of notifications for Mycobacterial disease (NOS) in 1991 compared to 1990 is due to delays in receipt of notifications. Updated figures are available from Epidemiology and Health Services Evaluation Branch. This branch is undertaking several measures to improve the notification of Mycobacterial disease.

The increased testing for hepatitis C is the most likely reason for the apparent increase in notifications for this condition. All notifications came from laboratories. Epidemiology and Health Services Evaluation Branch is producing a statewide strategy for hepatitis C. (Also refer to PHB 1990;1:39-40.)

Measles cases have been reported from four Public Health Units. The Hunter AHS still reports cases — for the seventh consecutive month.

We report the third case of tetanus since December, 1990. As in the two previous notifications, the case was of an elderly person — an unimmunised 72-year-old female. The source of infection is not known. Advice from our previous reports must be restated: ten-yearly immunisation against tetanus and diphtheria should be routine; where primary immunisation has not been undertaken, it should be begun.

Ross River Virus notifications are rising seasonally — notifications have been received from four Regional PHUs. Orana and Far West reported RRV at a rate of 3.6/100000/month, and New England reported it at a rate of 3.7/100000/month.

**TABLE 1**

<table>
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* Preliminary data only
### Table 2

**INFECTIOUS DISEASE NOTIFICATIONS, BY HEALTH AREA & REGION**

For January, 1991

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Abbreviations used in this Bulletin:

CSA Central Sydney Health Area, SSA Southern Sydney Health Area, ESA Eastern Sydney Health Area, SWA South Western Sydney Health Area, WSA Western Sydney 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 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 by the date of notification or receipt of such notification.

### Table 3

**INFECTIOUS DISEASE NOTIFICATIONS*, BY HEALTH AREA & REGION, NSW**

January, 1991

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*Notifications on interstate and overseas residents visiting NSW accounted for an additional 20 cases

**Rate per 100,000 population
VIBRIO VULNIFICUS DEATH

A 60-year-old man died on February 4 from septic shock after he lacerated his leg while collecting oysters. A full report on the case will be published in a future Public Health Bulletin. Health Department pamphlets on vibrio vulnificus are available from Public Health Units.

MARCH PHU MEETING

The March 7 Public Health Unit meeting in the level 10 conference room of the Health Department at North Sydney heard reports from the sub-committees on infectious disease and environmental health. Details will be published in the next Bulletin. After a morning meeting of Unit directors there was a general meeting at which a new sub-committee on reproductive health was formed.

CUTTING INJURIES — AND COSTS

A Sydney seminar on March 13 heard how hospitals and health care organisations in NSW could reduce workplace injuries and make immediate workers compensation savings by initiating better health management of their employees.

The seminar — Australia's health industry: reducing injuries, reducing costs — provided guidelines and case studies on how to protect health workers from hazards arising from sharp instruments, back injuries, stress, dangerous substances, shiftwork and assault. It pointed out that tackling occupational health and safety problems faced by health workers was urgent as public health care organisations faced greater requirements for accountability and private organisations grappled with the pressures of recession.

NSW Health Minister Peter Collins opened the seminar, which was organised by Sydney Hospital Occupational Health and Safety Service and Newsletter Information Services. Chief executive of the National Association of Nursing Homes and Private Hospitals, Kerry Jones, gave the keynote address on how to cost OH&S programs to ensure the best value for time and money spent.

This article has been extracted from Lancet in response to a request from the Infectious Diseases Special Interest Group.

The High Court in England has suggested that pertussis vaccine actually protects against encephalopathy — in contrast to earlier estimates that the vaccine is implicated in brain damage in 1 in 310,000 immunisations. The National Childhood Encephalopathy Study (UK 1981) was reanalysed in the light of various selection biases within that study and that the previously held results refer to an interim report.

The Canadian immunisation guide has been changed to read: “Although there may be an increased risk of acute, severe neurological illness (including encephalopathy) occurring within 72 hours of the administration of pertussis vaccine to previously healthy infants, the majority of such illnesses observed in the National Childhood Encephalopathy Study were prolonged or complex convulsions. All such children were normal on follow-up 12-18 months later.”

PUBLIC HEALTH EDITORIAL STAFF

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Suggestions for improving the reporting of infectious diseases are most welcome.