

NSW Respiratory Surveillance Report - week ending 06 August 2022

COVID-19 Summary

- NSW is continuing to experience a new wave of transmission driven by the BA.4 and BA.5 COVID-19 subvariants. Data suggest that COVID-19 infections and hospitalisations have peaked.
- PCR testing for COVID-19 has decreased, with 231,800 PCR tests reported this week, which is 7% lower than last week. The proportion of PCR tests that were positive for COVID-19 remained stable at 16%.
- The rate of COVID-19 notifications has decreased across all Local Health Districts and all age groups.
- The number of people in hospital with COVID-19 has decreased by 4% to 2,183 at the end of this week compared to 2,267 at the end of last week. There were 824 people with COVID-19 admitted to hospital and 69 people admitted to ICU this week. The seven-day rolling average of daily hospital admissions decreased by 20% to an average of 118 daily admissions from 147 last week. ICU admissions decreased to an average of 10 admissions by the end of this week, compared with 12 admissions at the end of the previous week. Hospital admissions data include people with COVID-19 who are admitted for other reasons.
- There were 200 COVID-19 deaths reported this week, a 22% increase from 164 reported last week. Only 139 (70%) had at least three doses of a COVID-19 vaccine, while another 22 had received two doses, four had received one dose and 30 had received no doses of a COVID-19 vaccine. The vaccination status of the remaining five were unable to be determined. Deaths may not have occurred in the week in which they were reported.
- BA.4 and BA.5 Omicron subvariants are currently the dominant strains, rising to 98% of tested samples at the end of this week compared to 97% at the end of the previous week. There is no evidence of a difference in disease severity between these and previous Omicron variants, this is being closely monitored.
- To help reduce severe disease from Omicron BA.4 and BA.5 subvariant infections, adults aged 50 to 64 are now recommended to receive a winter booster dose of a COVID-19 vaccine, adults aged 30 to 49 years can also receive a winter booster dose.

Other respiratory viruses summary

- Influenza activity has returned to low levels but influenza vaccination continues to be recommended.
- Hospitalisations and the percentage of tests that are positive are the most useful indicators for comparison of influenza activity across years. These indicators are not impacted by overall testing in the community, which is currently elevated due to increased respiratory virus testing.
- Of the 67,722 tests conducted for influenza at sentinel laboratories, the proportion of positive tests remained stable at below 1%.
- Emergency department presentations for 'influenza-like illness' (ILI) requiring an admission have decreased to 12 compared to 22 admissions in the previous week. 11% of all ILI emergency department presentations required a hospital admission this week.
- Detections of respiratory syncytial virus (RSV) have decreased this week. Data from sentinel laboratories show 2,117 cases detected this week, compared to 2,225 cases detected last week.
- Detections of RSV are likely impacted by increased levels of testing for respiratory viruses compared to previous years.
- Emergency department presentations for bronchiolitis (often caused by RSV) continue to be above the usual seasonal level but are decreasing after a peak in early July.

Data sources

The NSW Respiratory Surveillance Report consolidates data from a range of sources to provide an understanding of what is happening in the community. This data includes laboratory results, hospital administrative data, emergency department syndromic surveillance, death registrations and community surveys.

COVID-19 hospital admissions, intensive care unit admissions, and deaths

- COVID-19 vaccines are very effective in preventing the severe impacts of infections with the virus. Over 95 per cent of people aged 16 and over in NSW have received two doses of a COVID-19 vaccine, while more than 68 per cent of people eligible for their third dose have received it. With such high vaccination coverage in the community, a greater proportion of people admitted to hospital or intensive care unit (ICU) with COVID-19 are now vaccinated with two or three doses. However, people who are not vaccinated remain far more likely to suffer severe COVID-19. The minority of the overall population who have not been vaccinated are significantly overrepresented among patients in hospitals and ICUs with COVID-19. Note that some people with COVID-19 who are admitted to hospital or ICU are admitted for conditions unrelated to their COVID-19 infection, and these admissions will not be prevented by vaccination.
- Despite the substantial protection from COVID-19 provided by vaccination, older age remains a significant risk factor for serious illness and death with COVID-19, particularly when combined with significant underlying health conditions.

Figure 1. Daily seven-day rolling average of people with COVID-19 admitted to hospital within 14 days of their diagnosis, NSW, 1 January to 06 August 2022

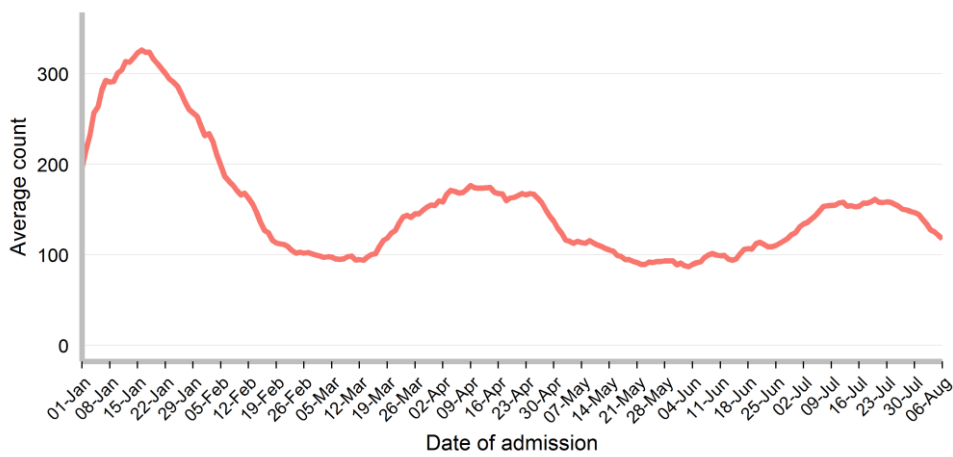


Figure 2. Daily seven-day rolling average of people with COVID-19 admitted to intensive care units, NSW, 1 January to 06 August 2022

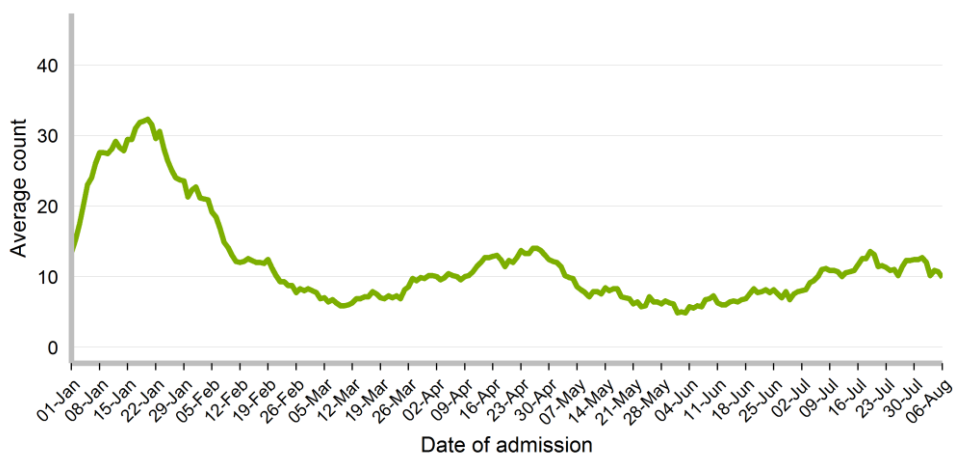
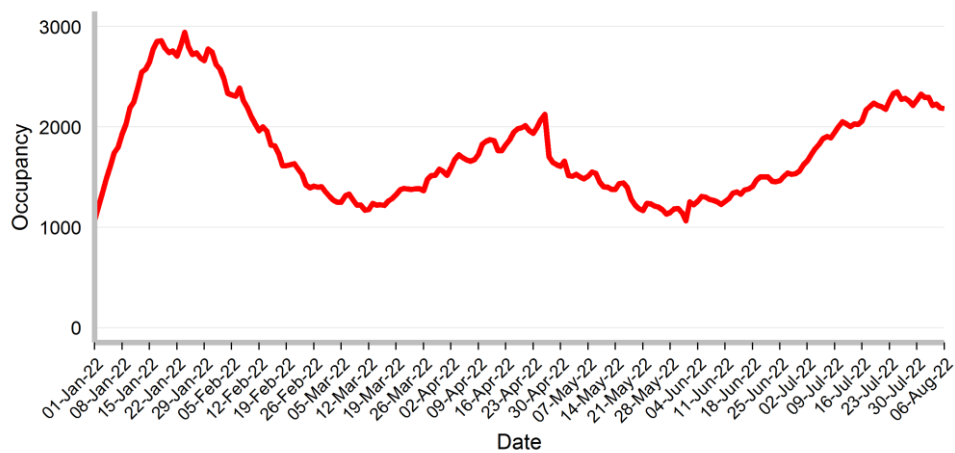


Figure 3. Number of people in hospital with COVID-19 by day, NSW, 1 January to 06 August 2022

- Hospital admissions in people with COVID-19 have decreased in the last week. ICU admissions for people with COVID-19 have decreased in the last week
- Eight hundred and twenty four people diagnosed with COVID-19 in the previous 14 days were admitted to a NSW public hospital. The seven-day rolling average of daily hospital admissions decreased to an average of 118 admissions by the end of this week, compared with 147 admissions at the end of the previous week.
- Sixty nine people diagnosed with COVID-19 were admitted to ICU. The seven-day rolling average of daily ICU admissions decreased to an average of 10 admissions by the end of this week, compared with 12 admissions at the end of the previous week
- The number of people in hospital with COVID-19 has decreased to 2183 at the end of this week compared to 2267 at the end of last week.

Table 1. People with a COVID-19 diagnosis in the previous 14 days who were admitted to hospital, admitted to ICU or reported as having died in the week ending 06 August 2022

	Admitted to hospital (but not to ICU)	Admitted to ICU	Deaths
Gender			
Female	398	28	101
Male	424	41	99
Not stated / inadequately	2	0	0
Age group (years)			
0-9	64	5	0
10-19	24	3	0
20-29	45	2	0
30-39	61	3	0
40-49	40	8	3
50-59	57	10	6
60-69	103	10	12
70-79	138	14	31
80-89	201	12	72
90+	91	2	76
Local Health District of residence*			
Central Coast	31	1	5
Illawarra Shoalhaven	57	3	17
Nepean Blue Mountains	36	1	5
Northern Sydney	88	10	34
South Eastern Sydney	76	7	23
South Western Sydney	121	8	23
Sydney	69	6	8
Western Sydney	108	9	24
Far West	3	0	1
Hunter New England	92	5	25
Mid North Coast	28	1	8
Murrumbidgee	38	0	8
Northern NSW	29	11	11
Southern NSW	8	1	5
Western NSW	33	4	3
Vaccination status^			
Four or more doses	197	15	76
Three doses	269	21	63
Two doses	142	10	22
One dose	12	1	4
No dose	0	1	30
Unknown	204	21	5
Total	824	69	200

*Excludes cases in correctional settings

^Vaccination status is determined by matching to Australian Immunisation Register (AIR) data. Name and date of birth need to be an exact match to that recorded in AIR. People with unknown vaccination status were unable to be found in AIR, though may have vaccination details recorded in AIR under a shortened name or different spelling.

- Of the 200 people who were reported to have died with COVID-19, only 139 (70%) had at least three doses of a COVID-19 vaccine, while another 22 had received two doses, four had received one dose and 30 had received no doses of a COVID-19 vaccine. The vaccination status of the remaining five were unable to be determined.¹
- Eighty five were aged care residents. Twenty five of these people died in hospital and 60 died at an aged care facility.
- Seven of the deaths occurred at home. All of these were diagnosed with COVID-19 prior to death.

Reported deaths were classified as COVID-19 deaths if they met the surveillance definition in the Communicable Diseases Network of Australia's COVID-19 National Guidelines for Public Health Units. Under this definition, deaths are considered COVID-19 deaths for surveillance purposes if the person died with COVID-19, not necessarily because COVID-19 was the cause of death. Deaths may be excluded if there was a clear alternative cause of death that was unrelated to COVID-19 (e.g. major trauma).

COVID-19 related deaths are notified to NSW Health from a range of sources, including public and private hospitals, aged care facilities, and the Coroner. Not all deaths reported by NSW Health occurred in the week in which they are reported as there is sometimes a delay between a death occurring and it being reported to NSW Health. NSW Health does not report deaths under investigation by the Coroner until the Coroner issues their findings on the cause of death.

¹ The Australian Technical Advisory Group on Immunisation (ATAGI) recommends that everyone aged 16 years and over has three doses of a COVID-19 vaccine, with an additional winter dose recommended for other people at increased risk of severe illness.

Epidemiological week 31, ending 6 August 2022

Notifications of COVID-19 and Influenza

Table 2. Notifications of COVID-19 and Influenza, by gender, age group, Local Health District, NSW, reported in the week ending 06 August 2022

	Week ending 06 August 2022		Year total	
	COVID-19	Influenza	COVID-19 *	Influenza
Gender				
Female	42,618 (53.4%)	457 (49.5%)	1,476,471 (52.4%)	58,601 (52.6%)
Male	37,044 (46.4%)	466 (50.5%)	1,335,855 (47.4%)	52,722 (47.3%)
Not stated / inadequately described	108 (0.1%)	0 (0.0%)	4,020 (0.1%)	153 (0.1%)
Transgender	0 (0.0%)	0 (0.0%)	4 (0.0%)	0 (0.0%)
Age group (years)				
0-4	3,381 (4.2%)	121 (13.1%)	129,546 (4.6%)	15,681 (14.1%)
5-9	5,400 (6.8%)	148 (16.0%)	184,710 (6.6%)	19,102 (17.1%)
10-19	10,739 (13.5%)	123 (13.3%)	408,190 (14.5%)	21,122 (18.9%)
20-29	11,042 (13.8%)	129 (14.0%)	459,698 (16.3%)	13,170 (11.8%)
30-39	13,008 (16.3%)	137 (14.8%)	490,569 (17.4%)	15,554 (14.0%)
40-49	11,692 (14.7%)	114 (12.4%)	416,032 (14.8%)	10,799 (9.7%)
50-59	9,835 (12.3%)	80 (8.7%)	321,727 (11.4%)	6,497 (5.8%)
50-69	7,231 (9.1%)	38 (4.1%)	220,714 (7.8%)	4,764 (4.3%)
70-79	4,548 (5.7%)	25 (2.7%)	119,168 (4.2%)	2,908 (2.6%)
80-89	2,166 (2.7%)	5 (0.5%)	50,025 (1.8%)	1,408 (1.3%)
90+	728 (0.9%)	3 (0.3%)	15,791 (0.6%)	458 (0.4%)
Local Health District of residence[#]				
Central Coast	3,479 (4.4%)	43 (4.7%)	122,430 (4.4%)	7,139 (6.4%)
Illawarra Shoalhaven	4,714 (6.0%)	96 (10.4%)	157,640 (5.7%)	6,259 (5.6%)
Nepean Blue Mountains	4,893 (6.2%)	20 (2.2%)	142,075 (5.1%)	6,197 (5.6%)
Northern Sydney	9,298 (11.7%)	113 (12.2%)	335,290 (12.0%)	11,646 (10.4%)
South Eastern Sydney	7,810 (9.9%)	80 (8.7%)	320,339 (11.5%)	11,672 (10.5%)
South Western Sydney	10,393 (13.1%)	70 (7.6%)	344,732 (12.4%)	16,487 (14.8%)
Sydney	5,789 (7.3%)	54 (5.9%)	238,182 (8.5%)	7,025 (6.3%)
Western Sydney	11,128 (14.1%)	93 (10.1%)	374,330 (13.4%)	16,276 (14.6%)
Far West	232 (0.3%)	1 (0.1%)	9,561 (0.3%)	262 (0.2%)
Hunter New England	10,887 (13.8%)	158 (17.1%)	336,530 (12.1%)	14,294 (12.8%)
Mid North Coast	1,878 (2.4%)	42 (4.6%)	63,323 (2.3%)	1,659 (1.5%)
Murrumbidgee	2,250 (2.8%)	18 (2.0%)	94,624 (3.4%)	3,131 (2.8%)
Northern NSW	1,801 (2.3%)	24 (2.6%)	82,678 (3.0%)	2,216 (2.0%)
Southern NSW	1,826 (2.3%)	36 (3.9%)	68,964 (2.5%)	1,885 (1.7%)
Western NSW	2,764 (3.5%)	71 (7.7%)	97,363 (3.5%)	5,001 (4.5%)
Aboriginal status[^]				
Aboriginal and/or Torres Strait Islander	3,127 (3.9%)	24 (2.6%)	101,816 (3.6%)	3,700 (3.3%)
Not Aboriginal or Torres Strait Islander	63,108 (79.1%)	474 (51.4%)	2,270,573 (80.6%)	53,706 (48.2%)
Not Stated / Unknown	13,535 (17.0%)	425 (46.0%)	443,961 (15.8%)	54,070 (48.5%)
Total	79,770 (100%)	923 (100%)	2,816,350 (100%)	111,476 (100%)

*Excludes 180,433 positive RATs registered up to 19 January 2022 for whom demographic information is not available.

[#]Excludes cases in correctional settings

[^]Aboriginal status is reported by COVID-19 cases when completing their RAT registration or responding to a short text message survey sent to cases detected by PCR. Not all cases respond to the question. For influenza cases, Aboriginal status is only known if it is collected and reported by the laboratory, which is not routine.

Figure 4. People notified with COVID-19, by date of test and type of test performed, NSW, 1 January to 06 August 2022

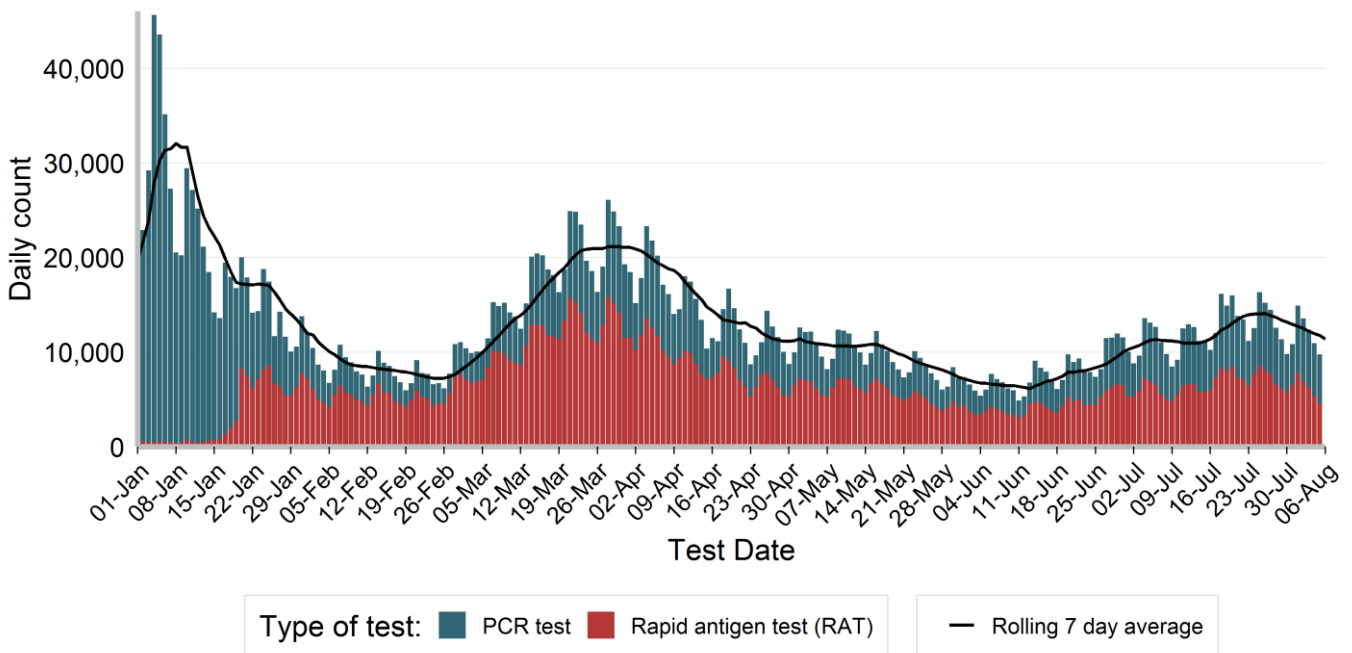
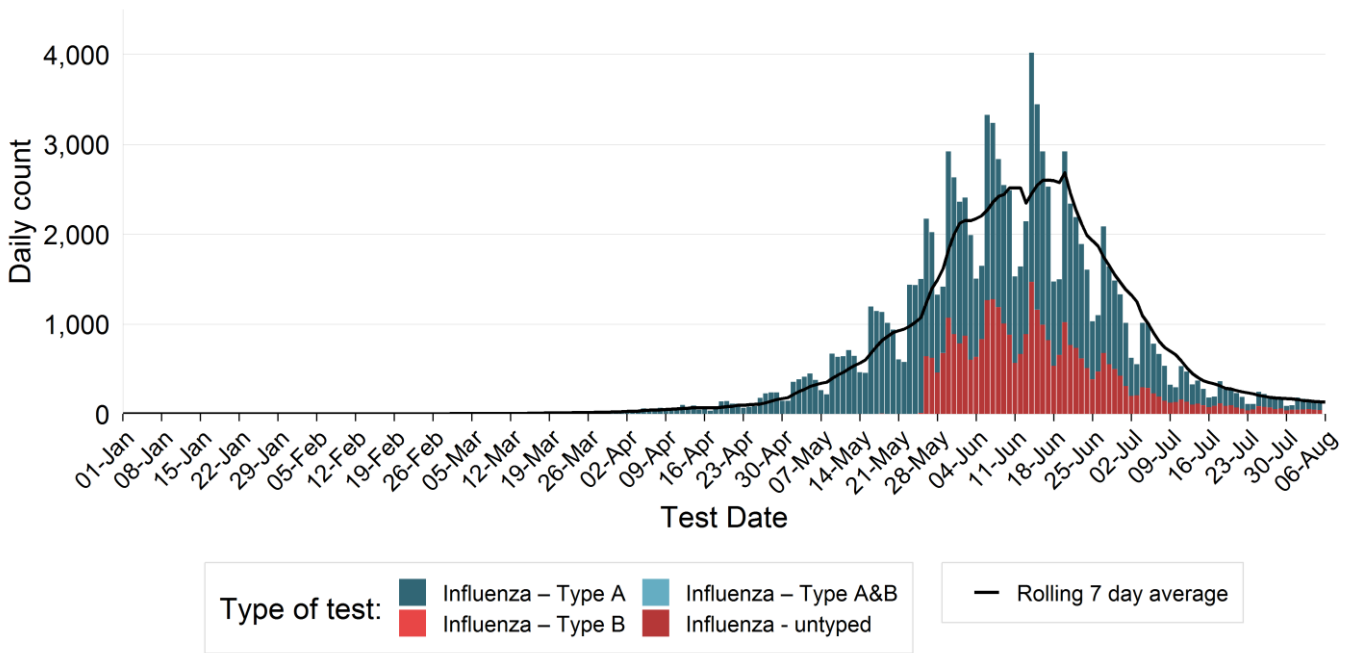


Figure 5. People notified with influenza, by date of test and virus type, NSW, 1 January to 06 August 2022



- There were 79,770 people diagnosed with COVID-19 this week, a decrease of 13.6% since the previous week.
- There were 923 people diagnosed with influenza this week, a decrease of 23.1% since the previous week.

Figure 6. Daily seven-day rolling average rate of COVID-19 notifications per 100,000 population, by age group and test date, NSW, 1 January to 06 August 2022

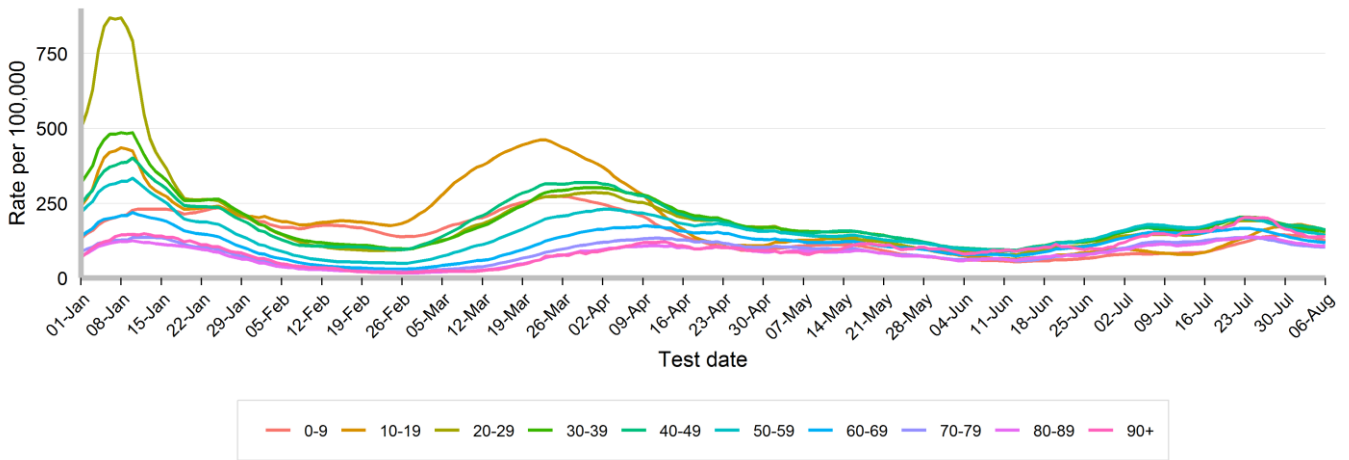


Figure 7. Daily seven-day rolling average rate of COVID-19 notifications per 100,000 population, by metropolitan Local Health District and test date, NSW, 1 January to 06 August 2022

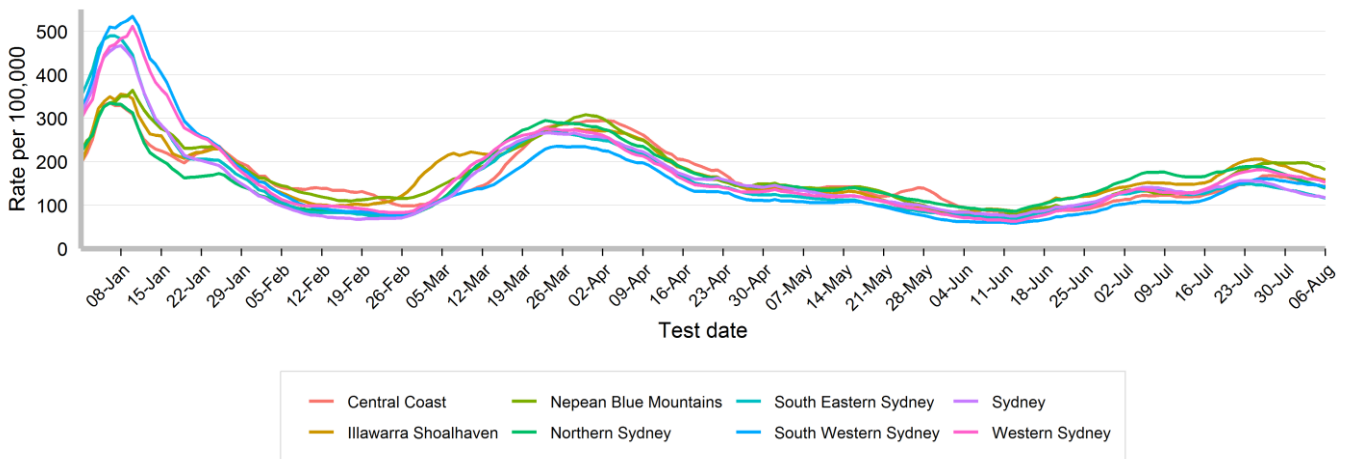
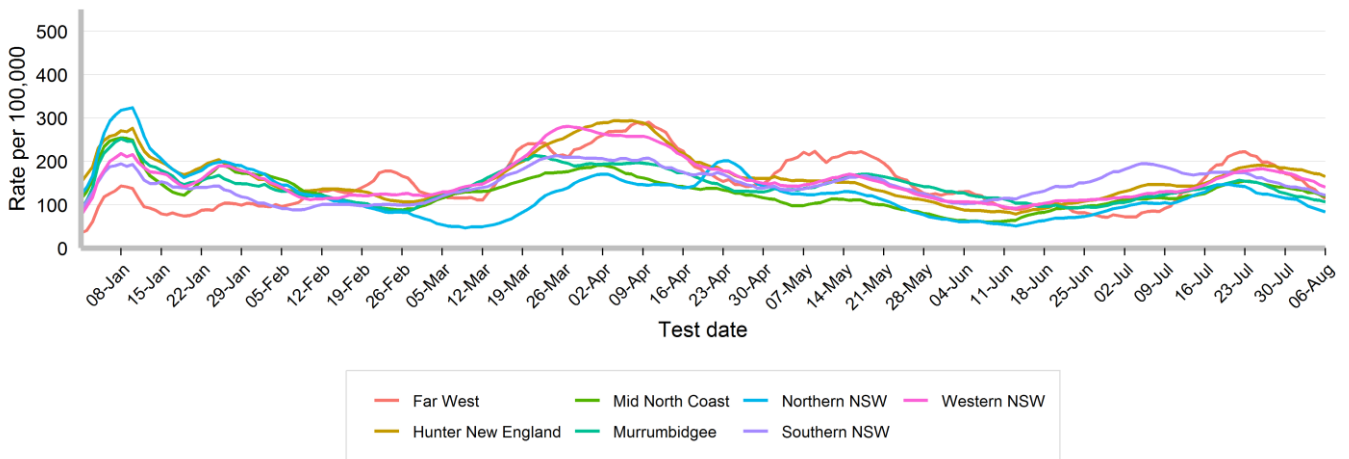


Figure 8. Daily seven-day rolling average rate of people reported with COVID-19 per 100,000 population, by rural and regional Local Health District and test date, NSW, 1 January to 06 August 2022



- The rate of COVID-19 notifications per 100,00 population has decreased across all Local Health Districts and all age groups.

Figure 9. Daily seven-day rolling average rate of influenza notifications per 100,000 population, by age group and test date, NSW, 1 January to 06 August 2022

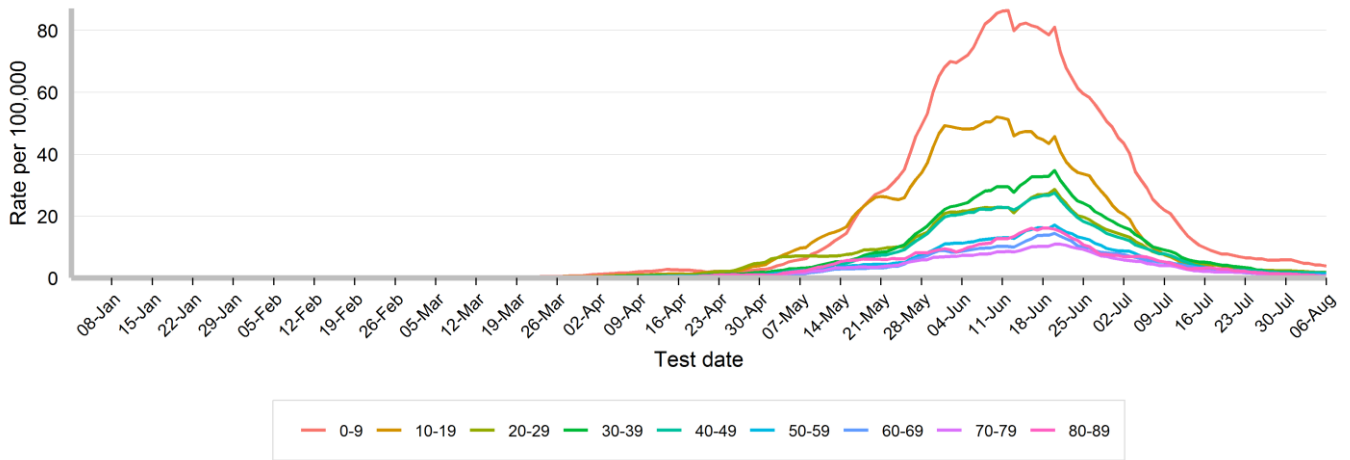


Figure 10. Daily seven-day rolling average rate of influenza notifications per 100,000 population, by metropolitan Local Health District and test date, NSW, 1 January to 06 August 2022

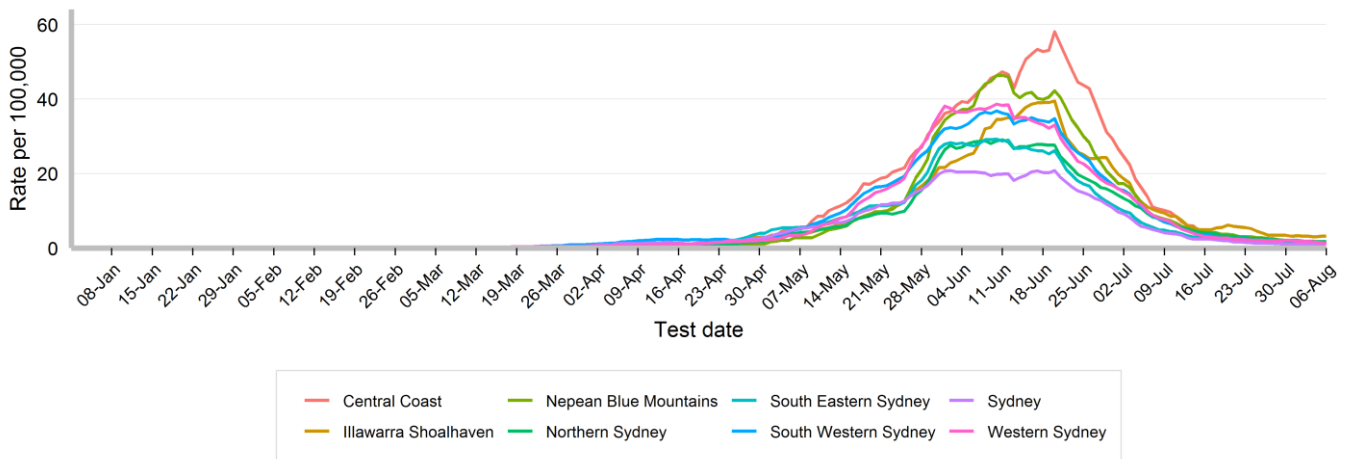
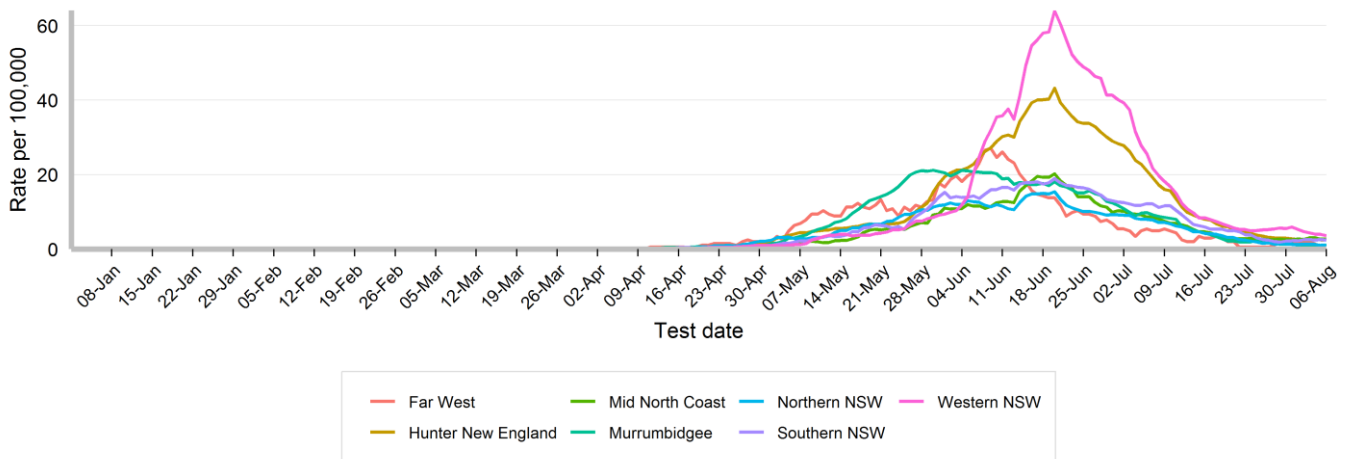


Figure 11. Daily seven-day rolling average rate of influenza notifications per 100,000 population, by rural and regional Local Health District and test date, NSW, 1 January to 06 August 2022



- The rate of influenza notifications per 100,00 population has decreased across all Local Health Districts and all age groups.

Emergency department and community surveillance

Public Health Rapid, Emergency, Disease and Syndromic Surveillance (PHREDSS) system

The NSW Public Health Rapid, Emergency, Disease and Syndromic Surveillance (PHREDSS) system provides daily monitoring of most unplanned presentations to NSW public hospital emergency departments (EDs) and all emergency Triple Zero (000) calls to NSW Ambulance. Emergency hospital presentations and ambulance calls are grouped into related acute illness and injury categories.

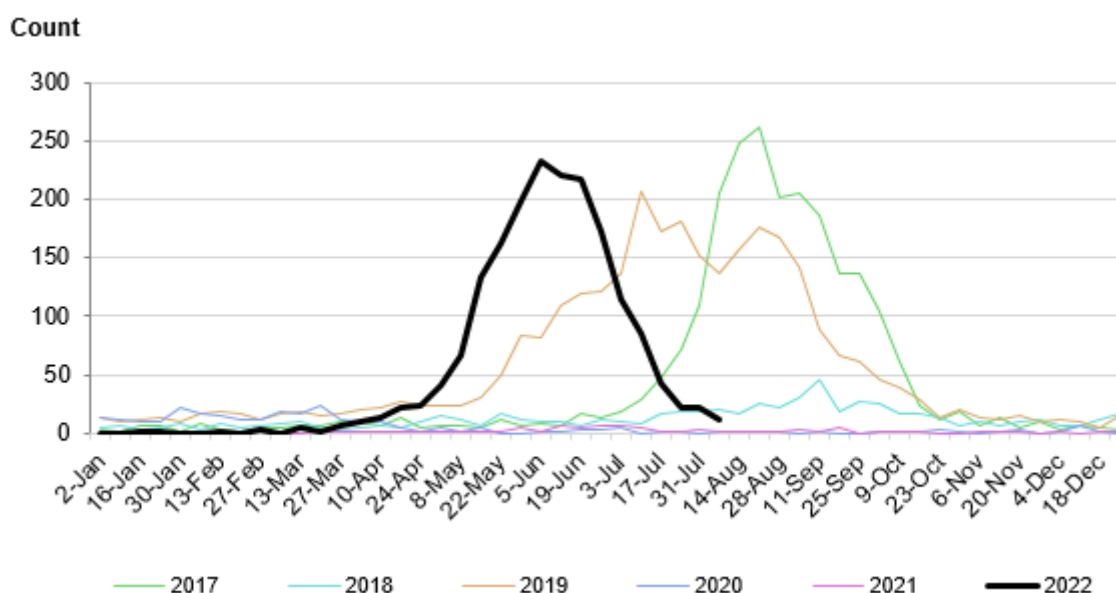
The number of presentations and calls in each category is monitored over time to quickly identify unusual patterns of illness. Unusual patterns could signify an emerging outbreak of disease or issue of public health importance in the population. PHREDSS is also useful for monitoring the impact of seasonal and known disease outbreaks, such as seasonal influenza or gastroenteritis, on the NSW population.

The 88 NSW public hospital EDs used in PHREDSS surveillance accounted for 95% of all ED activity in NSW public hospitals in 2020-2021, including most major metropolitan public hospitals (99%) and rural public hospitals (89%).

The emergency department '*influenza-like illness*' surveillance syndrome includes provisional diagnoses of ILI, influenza, including pneumonia with influenza and avian and other new influenza viruses. Influenza-like illness does not include COVID-19. The number of emergency department presentations for ILI reflects only a fraction of the impact of influenza on emergency departments but it is a useful marker of seasonal timing and trends. The number of presenting patients requiring an admission also provides an indication of severity.

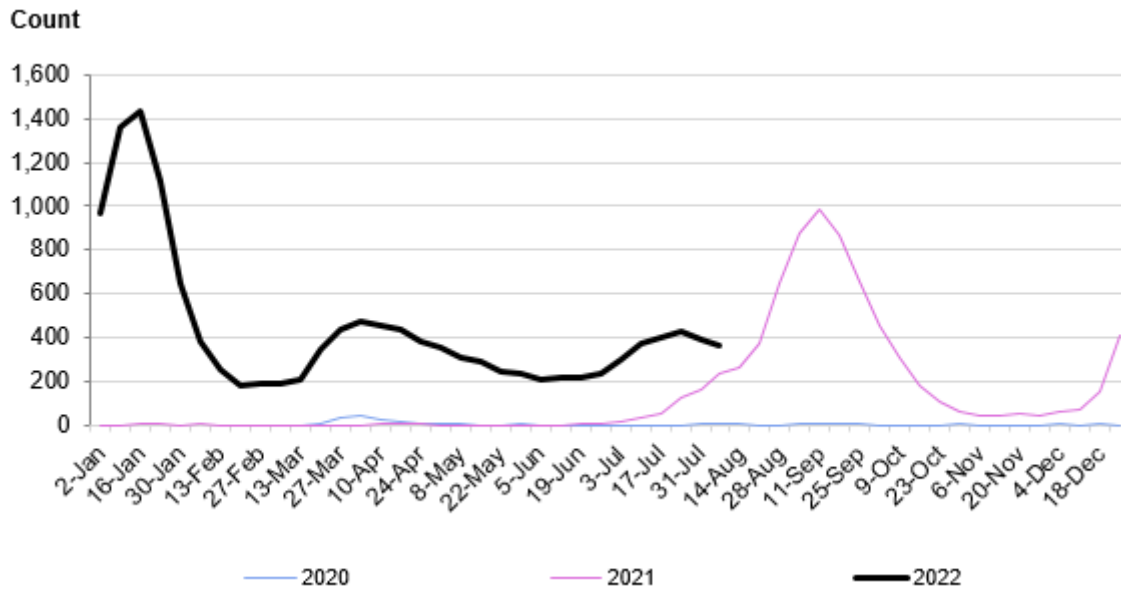
The emergency department '*coronaviruses/SARS*' surveillance syndrome includes provisional diagnoses (SNOMEDCT and ICD-10-AM codes) for coronavirus infections SARS, MERS, COVID-19 or other coronaviruses, or clinical condition of Severe Acute Respiratory Syndrome (SARS). It excludes testing and suspected coronavirus codes. There are no IDC-9 codes for COVID-19, so COVID-19 ED presentations at Albury Hospital will be mapped to the fever/unspecified infection surveillance syndrome. A person with COVID-19 may be admitted for reasons other than COVID-19, and of this the number of admissions from ED with a diagnosis of coronaviruses/SARS will be less than the number of confirmed cases of COVID-19 who are in hospital.

Figure 12. Weekly counts of unplanned emergency department (ED) presentations for '*influenza-like illness*', that were admitted, for 2022 (black line), compared with the previous five years (coloured lines), persons of all ages, 88 NSW hospitals



- Emergency department presentations for '*influenza-like illness*' (ILI) requiring an admission have decreased to 12 compared to 22 admissions in the previous week. This represents 11% of all ILI emergency department presentations this week.

Figure 13. Weekly counts of unplanned emergency department (ED) presentations for ‘coronaviruses/SARS’, that were admitted, for 2022 (black line), compared with the previous two years (coloured lines), persons of all ages, 88 NSW hospitals

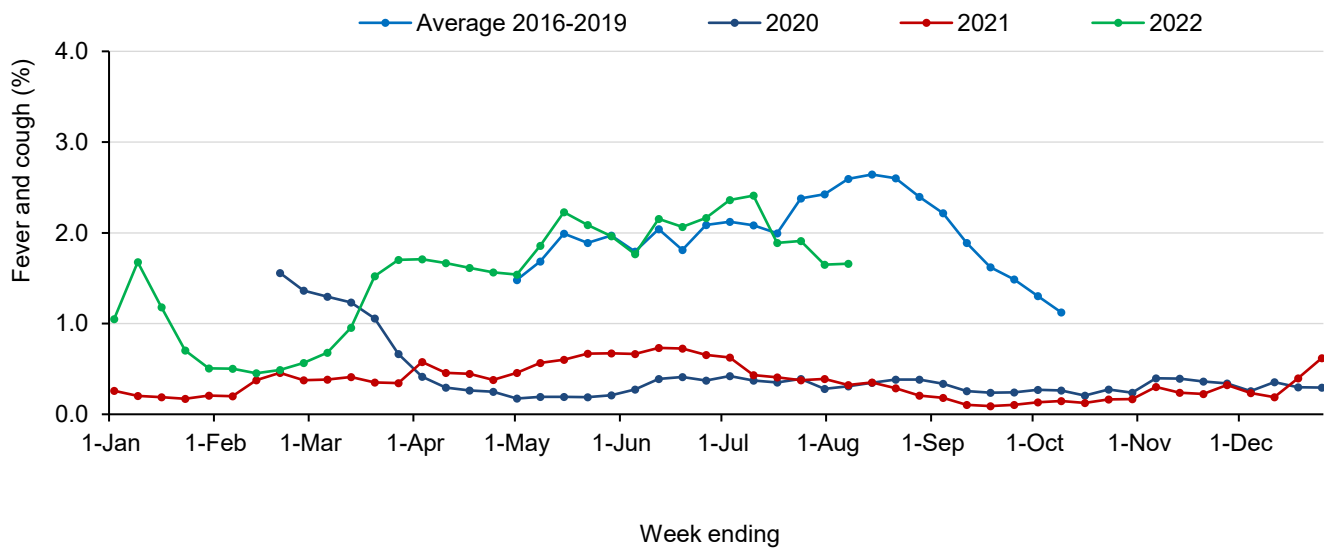


- Emergency department presentations for coronaviruses/SARS requiring an admission have increased/decreased to 367 from 394 admissions in the previous week.

FluTracking

FluTracking is an online health surveillance system used to detect epidemics of influenza across Australia and New Zealand. Participants complete an online survey each week to provide community level influenza-like illness surveillance, consistent surveillance of influenza activity across all jurisdictions over time, and year to year comparisons of the timing, attack rates and seriousness of influenza in the community. More information about FluTracking and ways to be involved are available here: <https://info.flutracking.net/about/>

Figure 14. Proportion of FluTracking participants reporting influenza-like illness, NSW, 1 January to 6 August 2022

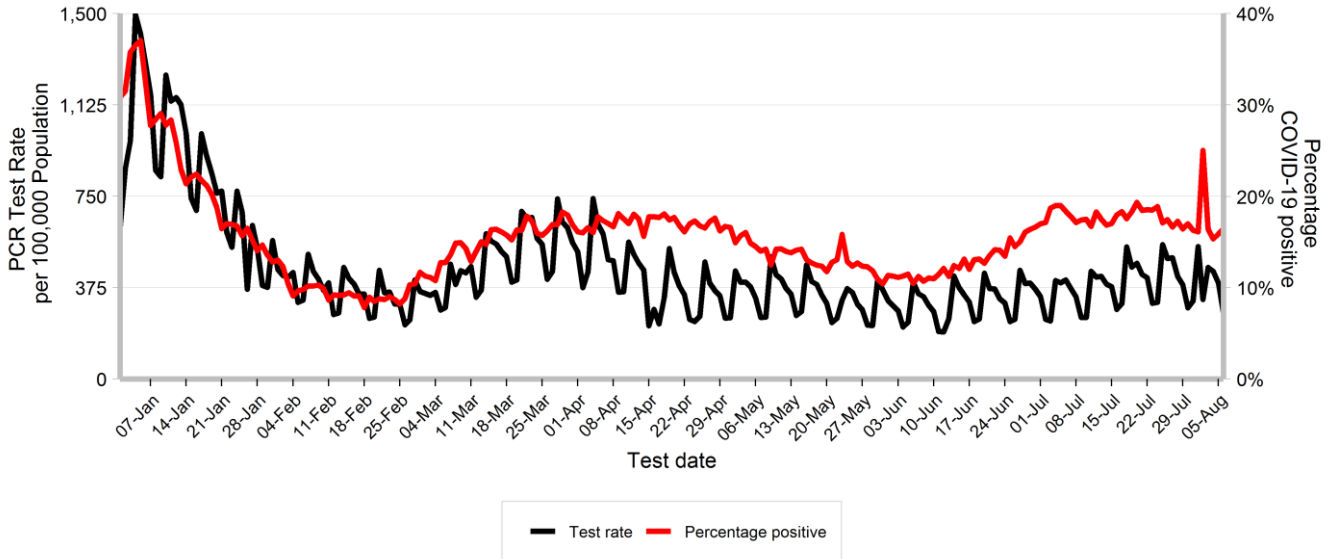


- The proportion of FluTracking participants reporting influenza-like illness remained stable this week.
- Additional FluTracking reports are available at: <https://info.flutracking.net/reports-2/australia-reports/>

LABORATORY SURVEILLANCE

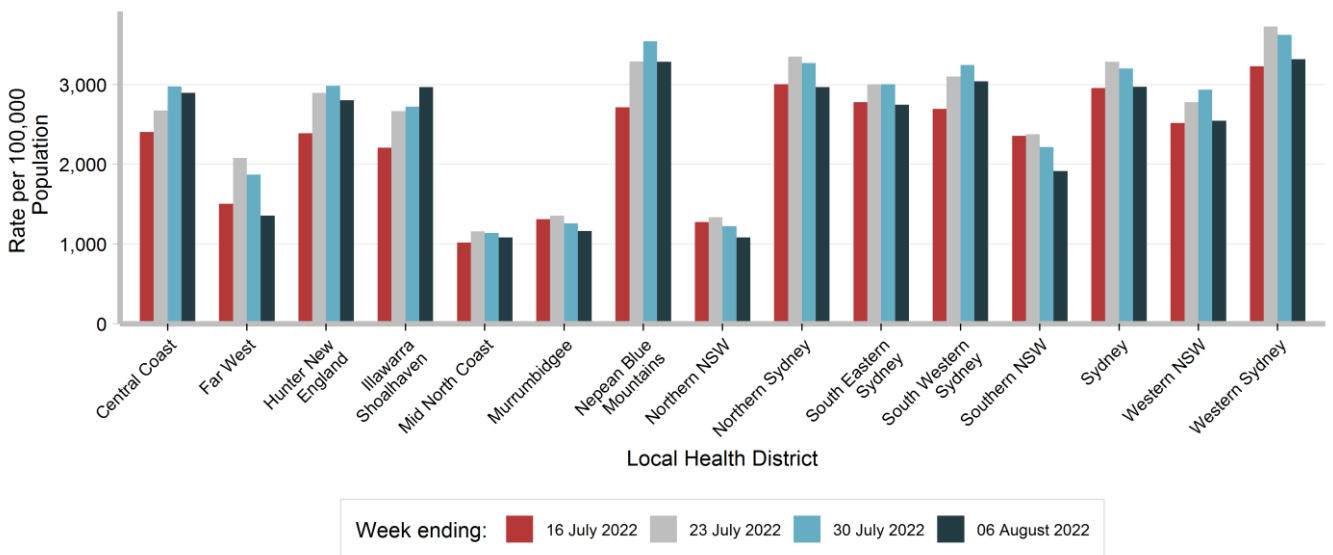
COVID-19 PCR testing

Figure 15. Rate of PCR tests for COVID-19 per 100,000 population per day, and percentage of PCR tests which were positive for COVID-19, by test date, NSW, 1 January to 06 August 2022



- There were 231,800 PCR tests reported this week. This is a 7.4% decrease compared to 250,227 PCR tests reported in the previous week.
- The percentage of PCR tests that were positive for COVID-19 has decreased to 16.5% compared to 17% at the end of the previous week.

Figure 16. Rate of PCR tests for COVID-19 per 100,000 population by Local Health District and test date, NSW, in the four weeks to 06 August 2022



COVID-19 Whole Genome Sequencing

Whole genome sequencing (WGS) is a laboratory procedure that identifies the genetic profile of an organism. WGS can help understand how a virus transmits, responds to vaccination and the severity of disease it may cause. It can also help to monitor the spread of the virus by identifying specimens that have are genomically similar. WGS has been used in NSW since the start of the COVID-19 pandemic to inform epidemiological investigations, and to monitor for and analyse the behaviour of new SARS-CoV-2 variants circulating in the community. WGS is conducted at three NSW reference laboratories. Prior to August 2021, low community transmission meant that most positive specimens were able to be sequenced. However, since that time high case numbers have required prioritisation of specimens for sequencing.

Specimens from people with COVID-19 who are admitted to hospital or an ICU are prioritised to identify and understand lineages with increased disease severity. Specimens from overseas arrivals are also prioritised to monitor for the introduction of new variants into the community. This is not a random sample, therefore the proportion of sequences identified is not necessarily reflective of their distribution in the community. There is a lag between the date a PCR test is taken and the date that the results of WGS are reported, therefore the count of sequences for recent dates will increase over time.

Variants of Concern

- Like all viruses, the SARS-CoV-2 virus changes over time. The World Health Organization monitors these changes and classifies lineages according to the risk that they pose to global public health. Those that they identify as having changes that increase transmissibility, increase virulence, or decrease the effectiveness of vaccines or treatments are designated as variants of concern (VOCs).

Table 3. Variants of concern (VOCs) identified by whole genome sequencing (WGS) of virus from people who tested positive for SARS CoV-2 by PCR, by test date, NSW, in the four weeks to 23 July 2022

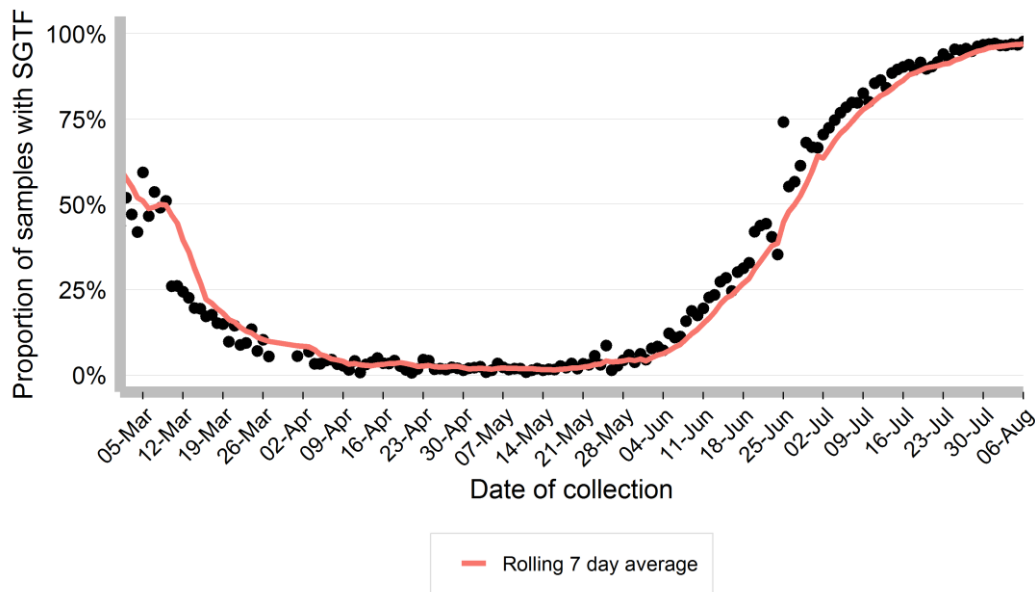
Variant	Week ending			
	09 July	16 July	23 July	30 July
Omicron (BA.2)	159 (17%)	99 (9.6%)	41 (5.2%)	42 (24.0%)
Omicron (BA.2.12.1)	40 (4.3%)	18 (1.7%)	13 (1.6%)	8 (2.9%)
Omicron (BA.2.75)	4 (0.4%)	5 (0.5%)	3 (0.4%)	9 (3.3%)
Omicron (BA.4)	111 (11.9%)	118 (11.5%)	72 (9.1%)	20 (11.4%)
Omicron (BA.5)	620 (66.2%)	790 (76.7%)	660 (83.7%)	194 (70.5%)
Omicron (BE.1)	1 (0.1%)	0 (0%)	0 (0%)	0 (0%)
Omicron (BE.3)	1 (0.1%)	0 (0%)	0 (0%)	0 (0%)
Dual Infection	0 (0%)	0 (0%)	0 (0%)	2 (0.7%)
Total	936	1030	789	275

- The Omicron variant is currently the dominant COVID-19 variant circulating in the NSW community. Most recent specimens have been identified as the BA.2 sub-lineage, however the proportion of specimens identified as BA.4 and BA.5 has been increasing in recent weeks, with BA.5 increasing more than BA.4.

S Gene detection as a proxy for the BA.2 omicron sub-lineage

- The BA.1, BA.4 and BA.5 subvariant of the Omicron variant have a mutation that results in a failure of certain PCR test platforms to detect the S gene. This mutation is typically not present in the BA.2 subvariant, and therefore the detection of an S gene can be used as a proxy to estimate the prevalence of BA.2 in the community.
- A PCR testing platform used by a large private pathology provider in NSW can routinely report on detection of the S gene in a specimen positive for SARS-CoV-2. Around 2% of SARS-CoV-2 positive specimens currently have an S gene detected. This indicates that the BA.2 subvariant likely makes up around 2% of the SARS-CoV-2 detected in NSW. The S gene failure specimens have been prioritised for WGS, with the majority of these now being identified as BA.4 and BA.5, rather than BA.1.

Figure 17. Proportion of samples with S gene target failure (SGTF), 1 March 2022 to 06 August 2022



Reported SARS-CoV-2 reinfections

The Communicable Diseases Network of Australia (CDNA) currently defines a SARS-CoV-2 reinfection as anyone who has a confirmed or probable infection more than 4 weeks after being released from isolation from their first infection. As the COVID-19 isolation period is typically 7 days, re-infection has been defined as notification of a positive test 36 days or more after the first positive test. All people with a first infection in January 2022 were checked for subsequent notifications at three time periods over five months to calculate the proportion of people reinfected. It is estimated that of the 639,430 people who were infected for the first time January 2022, 20,460 (3.2%) were infected again within 150 days. The likelihood of reinfection will be influenced by the characteristics of the variants and subvariants particularly their ability to escape immunity, the immune profile of the community and the level of infection in the community

Month of initial infection	Number of cases	Number of reported reinfections*		
		Within 90 days	Within 120 days	Within 150 days
January	639,430	10,846 (1.7%)	16,207 (2.5%)	20,460 (3.2%)

*reinfection must be at least 36 days after the initial infection, periods are cumulative meaning that those within 150 days also includes those with 120 and 90 days.

The following limitations need to be considered when interpreting this data:

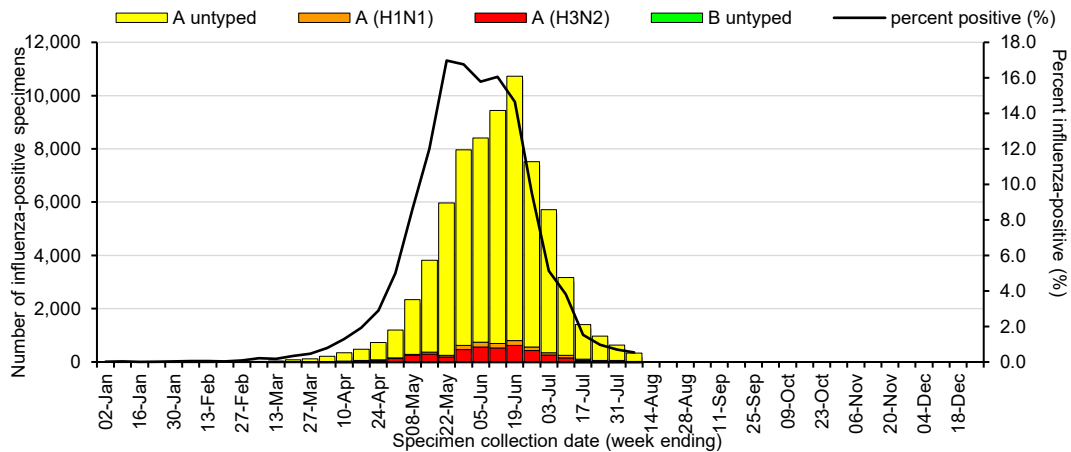
- Reinfections have been determined by matching name and date of birth, which can sometimes be inaccurate.
- If a person is not tested then a reinfection will not be reported.
- Some people (particularly those who are immunocompromised) can continue to test positive for a considerable time after their initial infection despite not acquiring a new infection. These people may be incorrectly included as having a reinfection.

This data covers a period where the subvariants of COVID-19 in the community were changing. The risk of reinfection for a person is influenced by the subvariant, and the timing and sequence of prior infections as well as their vaccination history

Influenza and other respiratory viruses

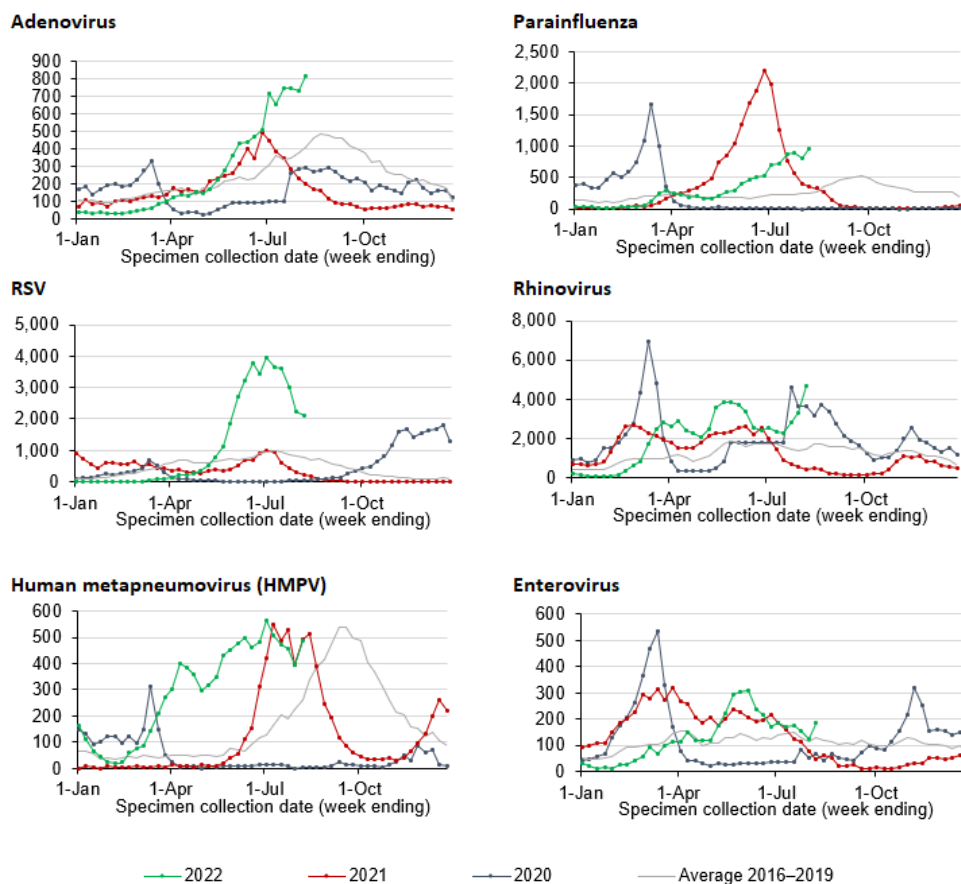
The NSW sentinel laboratory network comprises of 13 public and private laboratories throughout NSW who provide additional data on positive and negative test results. This helps us to understand which respiratory viruses are circulating as well as how much

Figure 18. Number and proportion of tests positive for influenza at sentinel NSW laboratories, 1 January to 7 August 2022



- Of the 67,722 tests conducted for influenza, the proportion positive has remained stable at below 1%

Figure 19. Number of positive PCR test results for other respiratory viruses at sentinel NSW laboratories, 1 January to 7 August 2022.



- Recent data is subject to change. For the week ending 7 August 2022, 10 out of 13 sentinel laboratories have provided testing data at the time of reporting.

Table 4. Total number of respiratory disease notifications from sentinel laboratories, NSW in the four weeks to 7 August, 2022

	Week ending				Year to date
	17 July	24 July	31 July	07 August*	
Adenovirus	745	749	732	818	8,542
Respiratory syncytial virus (RSV)	3,589	3,024	2,225	2,117	37,446
Rhinovirus	2,267	2,806	3,311	4,674	65,616
Human metapneumovirus (HMPV)	470	459	394	488	9,236
Enterovirus	176	157	124	183	4,125
Number of PCR tests conducted	91,903	98,688	90,334	67,722	1,259,427

*Recent data is subject to change. For the week ending 7 August 2022, 10 out of 13 sentinel laboratories have provided testing data at the time of reporting.