



## ASTHMA STRATEGY NEEDED

In responding to the problem of asthma, the NSW Department of Health should think and act strategically and not follow the non-strategic path that has so far led to there being no goals, no targets, and no systematic, time-framed, costed programs to:

- reduce asthma mortality;
- reduce asthma morbidity;
- prevent asthma death;
- prevent asthma;
- educate asthmatics; or
- educate doctors about asthma in NSW.

Ann Woolcock is the only person in Australia who has tackled this issue strategically and her efforts are embodied in the goals and targets pertaining to asthma contained in *Health for All Australians*<sup>1</sup>. The relevant section (pp 55-56) of that document is reproduced below. The NHMRC Working Party on Asthma-associated deaths did not develop a strategic plan to deal with asthma. The other professional associations mentioned have not either, although an eight point plan for individual patient management has been developed (see below).

Deaths from asthma in Australia have doubled since 1978 after falling steadily during the previous decade. For the period 1977-1986 there were 5,668 deaths. The terms of reference of the Working Party on Asthma Associated Deaths, recently established by the NHMRC Health Care Committee, include a brief to "recommend action that should be taken now to reduce mortality from asthma".

Deaths are the tip of the iceberg in any wider assessment of the problem. The Asthma Foundation of New South Wales estimates that one in ten adults and one in five 5-9 year olds are asthmatic although no national prevalence surveys have been undertaken in this country.

The cost of asthma to the community is not known. In 1984-5 therapeutic preparations for controlling bronchial spasms totalled 6.6 percent of total prescriptions under the Pharmaceutical Benefits Scheme, costing Australian taxpayers \$52.5 million (6.9 percent of the total government outlay for drugs). In addition there are very considerable costs associated with hospitalisation and patient care in the community. The social costs to patient and family are inestimable.

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### Goals and targets

The Committee found no evidence of goal or target setting for asthma in Australia and, in view of the prevalence of the disease, the distress it causes and the recent rise in asthma deaths it considers their development to be one of the most neglected in the entire field of community health.

It is therefore recommended that the proposed National Health for All Committee, in association with the NHMRC, the Asthma Foundation, the Thoracic Society of Australia and other interest groups, be given the task of developing specific goals and targets in this field as a matter of urgency.

The chair of the NHMRC Working Party on Asthma Associated Deaths has nominated the following areas as important in the formulation of a national asthma control program:

- identification and prevention of avoidable deaths from asthma;
- prevention of the development of abnormal lung function;
- prevention of the disease in infants who are at high risk;
- maintenance of normal airway function in all patients with asthma, thus preventing acute episodes;
- reduction of the level of bronchial hyper-responsiveness; and
- reduction of the prevalence of severe allergy in young children . . .

### GOAL: TO REDUCE ILLNESS AND DEATH

To be critical of the absence of strategic thinking and planning is not to gainsay the well-motivated efforts of individual doctors, parents, asthmatics and the Asthma Foundation of NSW. Rather, such comment is intended to draw attention to the necessity for an alternative approach to the non-strategic approaches which have been used, often in a muddled way, usually based more on goodwill and ideology than on empirical evidence of effectiveness.

Research can be planned within the context of an overall strategy for asthma control. There are four obvious gaps in our knowledge and control of asthma in NSW which (in view of the likely prevalence, morbidity and treatability of asthma) deserve to be bridged by a systematic approach to research. These are dealt with as follows:

### ■ THE BURDEN OF ILLNESS

While we know anecdotally that asthma is a common health problem in NSW and we know the number of reported deaths from asthma each year, we do not have statewide figures for the burden this illness inflicts on the community. Guy Marks at Royal Prince Alfred Hospital is working on the development of a scale of quality of life associated with asthma. This could form a good beginning for us to get a better idea of the amount of suffering, absenteeism and social disruption asthma causes at present. It would need to be used in surveys that could also estimate the prevalence of the condition.

Peter Curzon<sup>2</sup> has undertaken surveys of the geographical distribution of asthma mortality and has standardised hospital separation rates (insofar as this is possible) and then mapped these to indicate areas in NSW that have high and low densities, proportionately, of deaths and hospital admissions. Such estimates may be used further to describe the burden of illness from asthma.

### ■ RISK FACTORS FOR DEATH FROM ASTHMA

As Ann Woolcock said in her keynote address in Boston in May to the American Lung Association, we are, with death from asthma, where we were 40 years ago (pre-Framingham) with regard to quantitating the risk factors for death from asthma.

To take one example, many clinicians will say that poor treatment is a severe risk factor for death from asthma, because people who die from asthma are commonly poorly managed. But isn't management of asthma poor in the entire community of asthmatics? The answer is yes. The next question, then, is how much more common is poor management among asthmatics who die compared to its frequency among asthmatics who do not die? We do not have the quantitative data needed to assist in lifting poor treatment out of conjecture onto a solid footing.

While Australia has higher-than-average rates of reported death from asthma, and has shown an increase in recent years in the number of asthma deaths in older citizens<sup>3</sup>, aetiological research has been limited to industrial asthma — Charles Mitchell and Bryan Gandevia's work on enzymes and red cedar, Michael Hensley's work on aluminium smelter exposure<sup>4</sup> and so forth. While Ann Woolcock

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and colleagues have looked at the role of differing allergen burdens in children in Wagga, Belmont and other places<sup>5</sup>; nothing spectacular has been done to formulate aetiological hypotheses or test these in the community. Michael Hensley and Richard Henry are looking at socio-economic status and related factors in an attempt to explain different asthma prevalence in Munmorah and Port Stephens children<sup>6</sup>.

No case-control study has yet been conducted in Australia either into the aetiology of asthma per se (comparing prevalence of carpets and blankets in the homes of children with asthma with the prevalence of mite media in the homes of children without asthma) and none has been done into death from asthma using free-living asthmatics in the community as controls. Case-control studies have been done using near-miss patients variously as cases or controls, but the contrasts are not likely to lead far in the search for causes of death from asthma.

### ■ RESPONSE TO TREATMENT

Long-term consequences of treatment with beta agonists and/or inhaled corticosteroids have not yet been documented in a formal cohort or post-marketing surveillance strategy. Research in New Zealand<sup>7</sup> connects the use of fenoterol with death from asthma in patients judged from medication and hospital admission data to be at increased risk of death. We have no mechanisms in place in Australia to detect deleterious effects of these treatments.

Liz Young and Adrian Bauman have some data about the adequacy or otherwise of treatment of asthma in Campbelltown. David Henry reports in Newcastle that 30 percent of inhaled beta agonists are sold over-the-counter without prescription<sup>8</sup>; a proposition supported by Jenkins et al study of anti-asthmatic drug use in Australia<sup>9</sup>. There are no data on the prevalence of use of a crisis plan by doctors, no data on the prevalence of lung function testing of asthmatic patients by GPs, no data on what proportion of community asthmatics are treated and no data on what proportion of people using bronchodilators have conditions other than asthma. Surveys of all these variables and factors could be undertaken

to provide a more complete picture of the challenges ahead.

Although some education programs for asthmatics have been evaluated by Adrian Bauman and others, these have so far been disappointing. We need to be imaginative and clear about what we might expect from asthma education in NSW. Liz Young and Adrian Bauman could perhaps draft a working paper of goals and targets and realistic strategies. This should be research based because of the lack of certainty about what to do.

Another possibility is a randomised trial of the Eight Point Plan for asthmatics, developed by Ann Woolcock and her colleagues in the Australian and New Zealand Thoracic Society<sup>10</sup>.

### ■ PREVENTION

Based on the work from the University of Sydney, a trial of house dust mite reduction, as a preventive manoeuvre, might be contemplated. This would have to involve the building industry (a good piece of intersectoral activity for a market-oriented government). As a prelude, the case-control study mentioned above of young asthmatics and non-asthmatics could be carried out.

### ■ RECOMMENDATIONS

- 1 That as part of the NSW participation in the National Program for Better Health, we develop a goal-and-target based strategic plan for the management of asthma in this State. This should be done by the formal establishment of a Project Planning Team which can set the goals and targets and construct the strategy. It should include the Asthma Foundation of NSW, the NSW Branch of the Australian and New Zealand Thoracic Society, the Royal Australian College of General Practitioners, the NSW Departments of Education and Health, project home developers (or anyone else from industry considered appropriate), basic scientists, epidemiologists and others. The plan should be developed within the next six months.
- 2 That such a plan encompass research (laboratory, clinical and public health) among its strategies.

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Professor James S. Lawson, Head of the School of Health Services Management, at the University of NSW has prepared the following public health abstracts from the literature.

## IMMUNISATION REVISITED

The improved health status that follows prosperity and industrial development usually reflects a shift away from infectious disease as a leading cause of death towards accidents, cardio-vascular disease and cancer. However even in industrial countries such as Australia, prevention of infectious diseases with vaccines remains highly cost effective.

The scientific revolution in modern biology — genetic engineering, peptide synthesis, cell production systems, live vectors — is finally generating widespread interest in vaccine research. There are possibilities for improving current vaccines or developing new vaccines in 12 conditions. The most important of these are the chlamydias (the cause of sterility and chronic pelvic disease and also blindness), cholera, *E. coli* (the cause of diarrhoeal disease), hepatitis A, herpes simplex (a common distressing STD), HIV, influenza, malaria, tuberculosis, schistosomiasis (a liver fluke which causes widespread disability in Africa and parts of Asia) and yellow fever. In addition, there are several improvements being developed for vaccine delivery, including:

- the elimination of the need for refrigeration as for example, hepatitis B
- an attempt to reduce the number of injections (which can be achieved by developing delayed release vaccines), and
- oral vaccines which are currently being re-examined.

There are two problems with vaccines. The first is the alarm caused by the AIDS epidemic, and the possibility that injections can spread HIV. This is a problem in developing countries where sterilisation and re-use of needles is difficult. The second is the problem of ill health caused by the vaccines themselves.

Robbins, A, Progress Towards Vaccines We Need And Do Not Have, *Lancet* 1990, 1436.

## IMPROVING A & E CARE

A British-based study has demonstrated that the quality of care of patients in accident and emergency departments can be improved considerably at no additional expense by introducing two simple measures:

- developing a simple trauma score as a measure of severity of injuries, and
- calling in a senior accident and emergency specialist to supervise the resuscitation of all seriously injured patients.

(This documents experience years ago when surgeons replaced recent medical graduates in major accident and emergency departments in Victoria. This ultimately led to the appointment of Directors of these departments in most hospitals during the 1970s and 1980s).

Fisher, RB & Dearden, CH, Improving the Care of Patients With Major Trauma in the Accident and Emergency Department, *Brit J Med* 1990, 300, 1560.

## THE FEMALE CONDOM

Changes in behaviour and barrier methods of contraception are at present the only ways of slowing the sexual transmission of the human immunodeficiency virus (HIV). The female condom therefore represents a new and potentially important addition to the existing choices. The female condom is made of polyurethane, and it covers the female vaginal surface. Studies in the United Kingdom, Thailand the United States have indicated that the use of female condoms is acceptable to many female sex workers and other women and provides a successful barrier to infection. However many male partners object to their use.

The importance of the female condom is that it empowers women in dealing with this important and sensitive public health problem.

Sakondhvat, C, The Female Condom, *American Journal of Public Health* 1990, 80, 4, 498.  
Stein, Z, HIV Prevention, The Needs For Methods Women Can Use *Am J Pub Health* 1990, 80, 4, 460.

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## Public Health Abstracts

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### HEPATITIS A FROM CONTAMINATED WATER

An American experience has demonstrated that infection with hepatitis A virus — which accounts for 40 per cent of all hepatitis infections — can occur from a contaminated water supply. The commonest form of transmission is through the fecal-oral route. Additional sources include ingestion of contaminated food.

Bloch, AB, Stramer, SL, Smith, JD, et al, Recovery of Hepatitis A Virus From a Water Supply Responsible for a Common Source Outbreak of Hepatitis A, *Am J Pub Health* 1990, 80, 4, 428.

### SUICIDE RATES CHANGE

Important changes have occurred in the pattern of suicide among young men throughout England and Wales. Among men aged 15 to 24 years in whom the rate of suicide had been fairly stable up to 1982, the rate has increased dramatically by 40 per cent during 1982 to 1987. In contrast, the rate among men aged 25 to 34 and 35 to 44 which increased steeply during the late 1970s seems to have stabilised and may even have started to fall. The suicide rate among women seems to have been falling throughout this same period. The cause of these changes is not known. Similar trends have been observed in Australia.

Burton, P, Lowy, A & Briggs, A, Increasing Suicide Rates Among Young Men in England and Wales, *Brit J Med* 1990, 300, 1695.

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3 That the NSW Department of Health discuss with its Health for All Committee specific budgetary allocation for the implementation of the service elements of this strategy, and with the Asthma Foundation of NSW the funding of the research elements of the strategy.

Stephen Leeder, Professor, and Wayne Smith, Community Medicine Registrar, Department of Community Medicine, Westmead Hospital.

1. *Health for All Australians*. Report of the Health Targets and Implementation (Health for All) Committee to Australian Health Ministers. AGPS, Canberra, 1988.
2. Curzon P, The Geography of Asthma in New South Wales, Keynote Address to Respiratory Disease in Agriculture Conference, Moree, June-July 1989.
3. Asthma in Australia. Strategies for reducing morbidity and mortality. Report of the NHMRC Working Party on Asthma Associated Deaths. Canberra 1988.
4. Abramson MJ, Wlodarczck JH, Saunders NA and Hensley MJ, Does Aluminium Smelting Cause Lung Disease? *Am. Rev. Respir. Dis.* 1989; 139: 1042-1057.
5. Peat JK, Salome CM and Woolcock AJ, Longitudinal Changes in atopy during a 4-year period: relation to bronchial hyperresponsiveness and respiratory symptoms in a population sample of Australia school children. *J. Allergy Clin. Immunol.* 1990 Jan; 85 (1 Pt 1): 65-74.
6. Henry RL and Hensley MJ, Prevalence and Severity of Asthma at Lake Munmorrah and Nelson Bay Primary Schools 1986-88. A report to the Electricity Commission of New South Wales. Feb 1989.
7. Crane J, Pearce N, et al, Prescribed fenoterol and death from asthma in New Zealand, 1981-1983: a case-control study. *Lancet* 1989; 917-922.
8. Henry DA, Sutherland D and Francis L, The use of non-prescription salbutamol inhalers by asthmatic patients in the Hunter Valley, New South Wales *Med. J. Aust.* 1989 Apr 17; 150 (8): 445-9.
9. Jenkin MA, Hurley SF, Bowes G and McNeil J, Use of antiasthmatic drugs in Australia, *Med. J. Aust.* 1990 Sept 17; 153: 323-328.
10. Woolcock A, Rubinfield AR, Seale JP et al, Asthma Management Plan, 1989 *Med. J. Aust.* 1989 Dec 4/18; 151: 650-653.

### EDITORIAL NOTE

This paper was prepared for a meeting of the Expert Working Group on Asthma held on July 24, 1990. Present at this meeting were prominent clinicians and public health professionals in the field of asthma.

Meeting participants resolved to develop and promote a co-ordinated strategy to reduce asthma morbidity and mortality in NSW. The Expert Working Group on Asthma will meet again in late 1990.

# INFECTIOUS DISEASES

## NOTIFICATIONS

This issue of the Public Health Bulletin contains two important changes in the presentation of infectious disease notifications (Tables 1 to 4). First, the notifications are presented on a calendar month basis. Second, notification rates are provided, both by health areas/regions and for the State as a whole. The denominators of the rates are estimates of the population residing in each area/region.

Overall, 52 percent of the notifications between January 1 and August 31, 1990 were from laboratories. There was a 16-fold variation in the rate of notifications by doctors among the areas/regions, and a 29-fold variation in the rate of notifications by laboratories. The largest number of notifications (1544) and the highest rate (477.7 per 100,000) came from the Eastern Sydney Area, followed by the North Coast Region (680 notifications, representing 199.2 per 100,000). The lowest number (40) and rate (21.0 per 100,000) came from the South East Region.

Three conditions together accounted for 2958 (49 per cent) of the 6031 notifications in the first eight months of 1990: campylobacter infection, non-specific urethritis, and salmonella infection. Key features of the notification patterns in August 1990, compared with August 1989, were as follows:

- Increases in notifications of some sexually-transmitted diseases, with relatively large numbers of notifications from the Eastern and South Western Sydney Areas (genital herpes, chlamydia infection and non-specific urethritis), and the Orana Far West Region (syphilis).
- An increase in measles notifications, with a large proportion coming from the North Coast Region, and others coming from the Hunter Area and the New England Region.
- An increase in notifications of meningococcal infections, with half of the notifications coming from the Southern and Western Sydney Areas, the remainder being scattered.
- An increase in notifications of salmonella infections, the largest numbers coming from the Northern and South Western Sydney Areas.
- An increase in notifications of shigella infections, predominantly from the Eastern Sydney Area.
- An increase in tuberculosis notifications, mainly from the Sydney metropolitan areas. The August increase was in contrast to the overall decrease during the first eight months of 1990, compared with the corresponding period in 1989.
- A decrease in AIDS notifications.
- A decrease in infantile diarrhoea notifications.

**TABLE 1**

**INFECTIOUS DISEASE NOTIFICATIONS, NSW August, 1990**

CONDITION	Number of Cases Notified			
	Period		Cumulative	
	01-08-90 to 31-08-90	01-08-89 to 31-08-89	1990	1989
AIDS	8	28	150	197
Amoebiasis	1	-	7	4
Ancylostomiasis	-	-	-	-
Anthrax	-	-	-	-
Arboviral infection (NOS)	-	-	1	-
Brucellosis	-	-	4	-
Campylobacter infection	89	93	1042	1293
Chancroid	-	-	-	-
Chlamydia infection (NOS)	25	13	163	18
Cholera	-	-	1	-
Congenital rubella syndrome	-	-	-	-
Diphtheria	-	-	-	-
Donovanosis	-	-	-	-
Encephalitis (NOS)	-	-	1	1
Food poisoning (NOS)	-	-	21	7
Genital herpes	77	14	454	474
Giardiasis	30	40	386	507
Gonococcal ophthalmia neo.	-	-	-	1
Gonorrhoea	18	21	267	425
Hepatitis A	2	4	16	52
Hepatitis B	28	23	201	312
Hepatitis C	-	N/A	7	N/A
Hepatitis unspecified	-	3	3	11
HIV	N/A	N/A	N/A	N/A
Hydatid disease	-	-	4	1
Infantile diarrhoea (NOS)	14	61	68	268
Legionnaires' disease	4	7	21	47
Leprosy	-	1	3	8
Leptospirosis	1	3	29	41
Lymphogranuloma venereum	-	-	-	-
Malaria	8	11	117	49
Measles	10	4	58	14
Meningococcal infection	16	5	58	39
Non specific urethritis	98	34	980	1197
Ornithosis	-	-	-	4
Pertussis	7	15	108	55
Plague	-	-	-	-
Poliomyelitis	-	-	-	-
Q fever	3	7	48	77
Rabies	-	-	-	-
Ross River fever	8	6	213	365
Rubella	-	-	1	-
Salmonella infection	71	19	936	906
Shigella infection	12	-	88	57
Syphilis	41	18	214	212
Tetanus	-	-	-	-
Trachoma	-	-	1	-
Tuberculosis	18	1	252	276
Typhoid & paratyphoid	2	-	22	13
Typhus	-	-	-	-
Vibrio infection (NOS)	-	7	7	14
Viral haemorrhagic fevers	-	-	-	-
Yellow fever	-	-	-	-
Yersinia infection	3	-	79	64

NOS - Not Otherwise Specified

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## Infectious Disease Notifications

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- A decrease in pertussis notifications. However, a one-month old baby girl died of pertussis on August 22. There were no other children in the family; the mother had had a cough, but no swab was taken. The issue of waning immunity among adults, and transmission to neonates has come to the attention of the Epidemiology and Health Services Evaluation Branch on at least one other occasion in the past four months. Pertussis immunisation of all children at two, four, six and 18 months is likely to improve protection of children too young to be immunised themselves.

The notifications undoubtedly under-estimate disease incidence, and some of the patterns described may result from changes in notification practices rather than changes in disease incidence. Nevertheless conclusions of great public health and clinical importance can be drawn. In particular, the measles and meningococcus notifications reaffirm the need for clinical vigilance, prompt reporting and the rapid implementation of appropriate public health action. Active measures have also been taken to treat syphilis cases and trace contacts.

## INFLUENZA SURVEILLANCE

This report follows that in the August Bulletin<sup>1</sup>. For the period June 4 to August 26, 1990 the proportions of all general practitioner (GP) consultations for both influenza like-illness and ICHPPC-2 defined influenza are shown in Figure 1. The proportions are expressed as the number of cases per 100 consultations.

By 26 August 1990, information from 31,543 GP consultations had been received by the Epidemiology Branch. The proportion of GP consultations relating to influenza-like illness was 3.8 percent, while the proportion fulfilling ICHPPC-2 criteria was 1.9 percent.

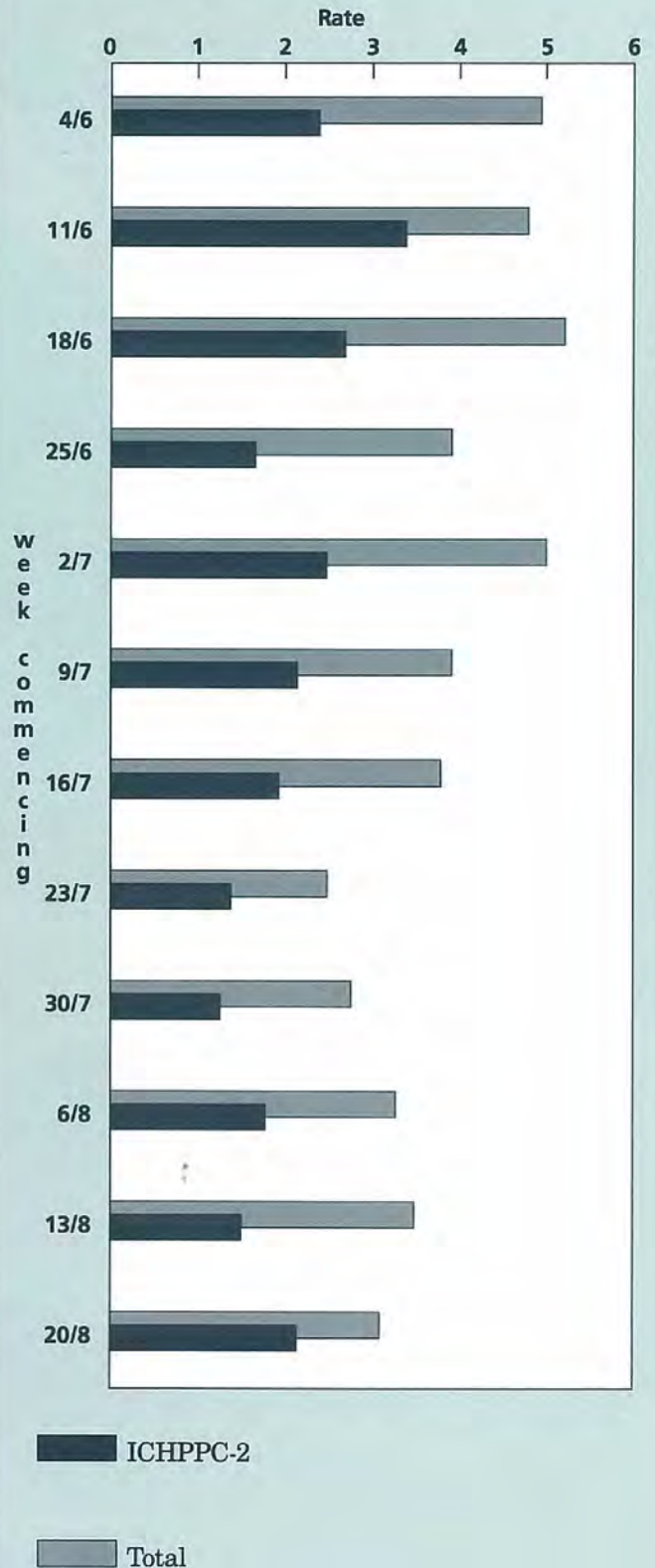
Of the people presenting with influenza-like illness who had been immunised this year against influenza, 58 percent were below the NHMRC recommended age of 65 years.

1. NSW Pub Health Bull 1990; 1(7-9):22

Infectious Disease Section  
Epidemiology and Health Services Evaluation Branch  
Department of Health, NSW

FIGURE 1

RATE OF INFLUENZA-LIKE ILLNESS  
June 4 to August 26, 1990

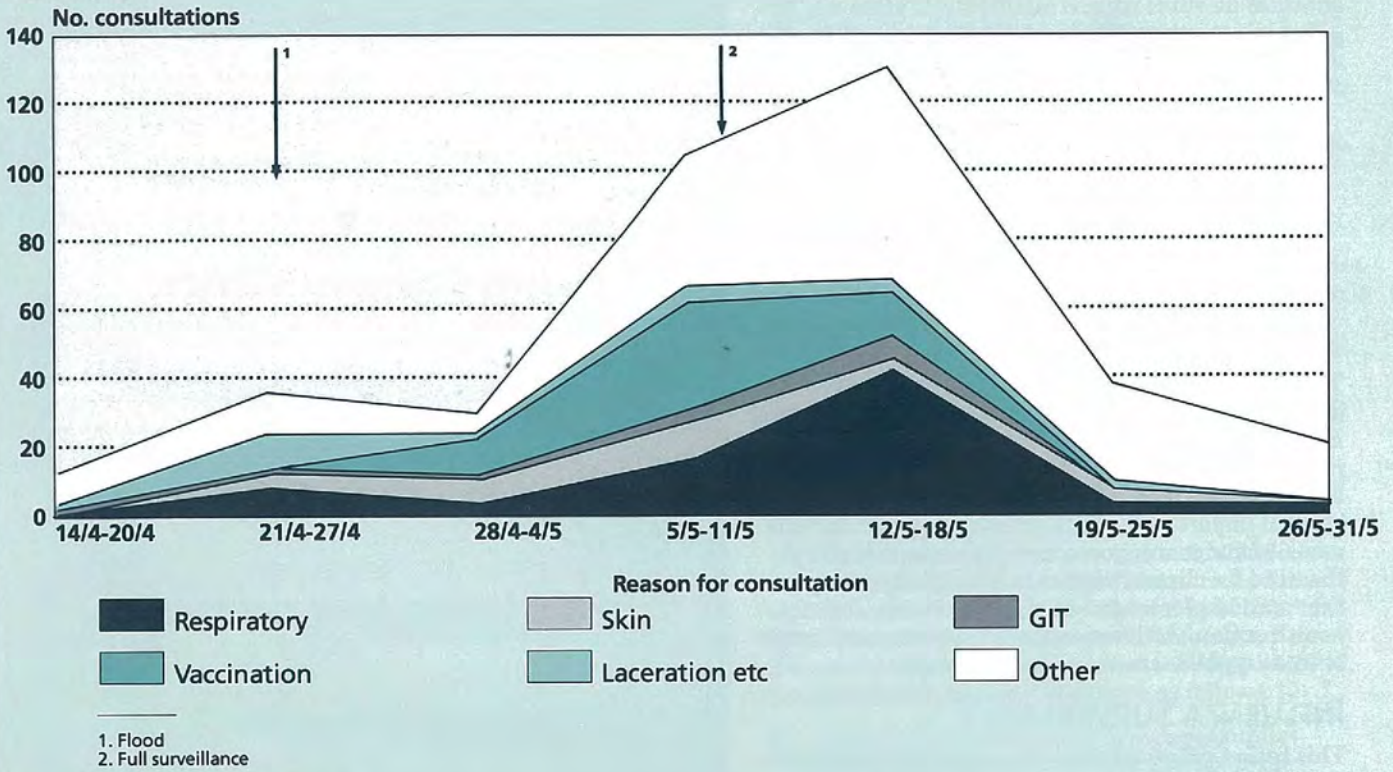


rate influenza/100 consultations

**FIGURE 2**

**NYNGAN GENERAL PRACTITIONER CONSULTATIONS**

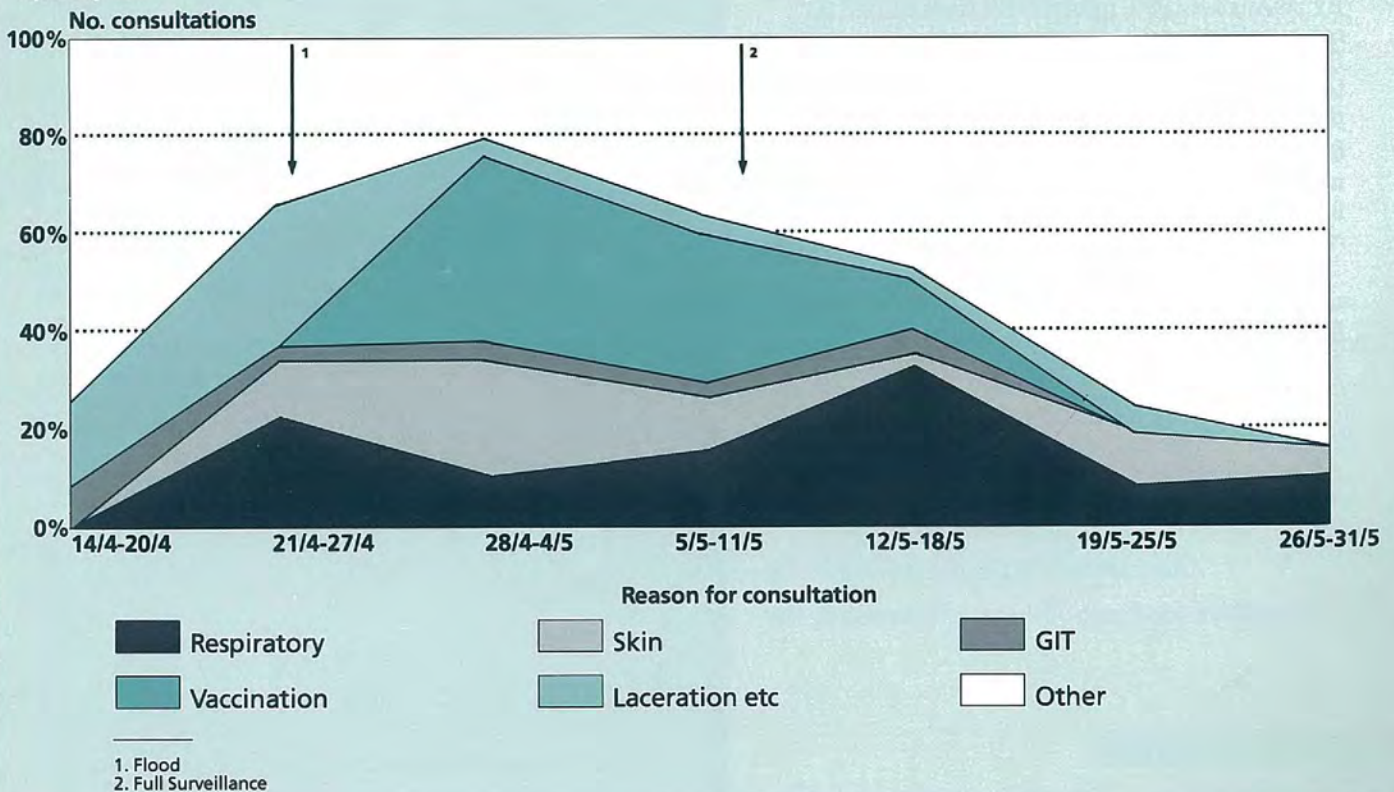
April/May 1990



**FIGURE 3**

**NYNGAN GENERAL PRACTITIONER CONSULTATIONS**

April/May 1990





**TABLE 2**

**INFECTIOUS DISEASE NOTIFICATIONS<sup>1</sup>,  
BY HEALTH AREA & REGION, NSW  
January 1 to August 31, 1990**

HEALTH AREA/REGION	DOCTOR NOTIFICATIONS	RATE <sup>2</sup> PER 100,000	LABORATORY NOTIFICATIONS	RATE PER 100,000	TOTAL NOTIFICATIONS	RATE PER 100,000
Central Sydney Area	216	64.8	81	24.3	297	89.1
Eastern Sydney Area	523	161.8	1021	315.9	1544	477.7
Southern Sydney Area	246	46.7	184	35.0	430	81.7
South Western Sydney Area	352	57.4	180	29.4	532	86.8
Western Sydney Area	191	32.4	162	27.5	353	59.9
Wentworth Area	127	47.6	183	68.5	310	116.1
Northern Sydney Area	196	27.0	166	22.9	362	49.8
Central Coast Area	80	37.0	23	10.6	103	47.6
Illawarra Region	156	52.6	50	16.8	206	69.4
Hunter Region	190	39.9	62	13.0	252	52.9
North Coast Region	179	52.4	501	146.8	680	199.2
New England Region	152	61.8	238	96.7	390	158.5
Orana & Far West	147	105.7	71	51.0	218	156.7
Central West Region	49	29.8	42	25.5	91	55.3
South West Region	36	14.4	45	18.0	81	32.3
South East Region	19	10.0	21	11.0	40	21.0
Unknown	4	0.1	66	1.2	70	1.2
<b>Total<sup>3</sup></b>	<b>2863</b>	<b>50.2</b>	<b>3096</b>	<b>54.3</b>	<b>5959</b>	<b>104.6</b>

1. Excludes HIV
2. Rate per 100,000 population
3. Notifications on Interstate and Overseas residents visiting NSW accounted for additional 72 cases.

**TABLE 3**

**INFECTIOUS DISEASE NOTIFICATIONS  
BY HEALTH AREA AND REGIONS  
FOR MONTH OF AUGUST 1990**

CONDITION	CSA	ESA	SSA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NCR	NER	OFR	CWR	SWR	IS	U/K	TOTAL
AIDS	2	2	1	-	-	-	2	-	-	-	-	1	-	-	-	-	-	8
Amoebiasis	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	1
Campylobacter inf.	7	6	9	9	11	13	6	2	-	1	8	13	1	2	-	-	1	89
Chlamydia infection	-	8	-	-	1	-	-	-	-	-	11	4	-	-	1	-	-	25
Genital herpes	-	40	-	3	2	8	-	-	-	-	11	5	4	3	-	1	-	77
Giardiasis	1	2	4	-	2	1	-	4	-	1	11	4	-	-	-	-	-	30
Gonorrhoea	-	10	-	1	1	2	-	-	-	-	2	1	1	-	-	-	-	18
Hepatitis A	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-	2
Hepatitis B	-	1	1	1	1	-	2	-	-	-	8	-	13	-	1	-	-	28
Infant diarr. (NOS)	-	-	-	-	-	-	-	-	-	-	13	1	-	-	-	-	-	14
Legionnaires' dis.	-	-	-	-	-	-	-	-	1	2	1	-	-	-	-	-	-	4
Leptospirosis	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1
Malaria	-	2	2	-	-	-	3	-	1	-	-	-	-	-	-	-	-	8
Measles	-	-	-	-	-	-	-	-	-	3	6	1	-	-	-	-	-	10
Meningococcal inf.	-	1	5	1	3	2	-	-	-	1	-	2	-	1	-	-	-	16
Nonspecific urethritis	-	77	-	14	1	-	-	-	-	-	2	1	3	-	-	-	-	98
Pertussis	-	-	3	-	-	2	-	-	-	-	-	1	-	-	-	-	1	7
Q Fever	-	-	-	-	-	-	-	-	-	-	-	3	-	-	-	-	-	3
Ross River virus	-	-	-	-	-	-	-	-	-	1	5	2	-	-	-	-	-	8
Salmonella inf.	5	7	2	12	9	3	14	2	4	6	1	2	1	-	-	-	3	71
Shigella inf.	-	7	-	-	-	-	1	-	-	1	1	2	-	-	-	-	-	12
Syphilis	2	12	1	5	-	-	-	-	-	1	5	3	12	-	-	-	-	41
Tuberculosis	-	3	2	5	2	-	2	-	-	2	-	1	-	1	-	-	-	18
Typhoid & paratyphoid	-	-	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	2
Yersinia inf.	1	-	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	3

Abbreviations used in this Bulletin:

CSA Central Sydney Health Area, ESA Eastern Sydney Health Area, SSA Southern 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, IS Interstate, U/K Unknown, OS Overseas, NOS Not Otherwise Stated

TABLE 4

INFECTIOUS DISEASE NOTIFICATIONS,  
BY HEALTH AREA & REGION  
January 1-August 31 1990

CONDITION	CSA	ESA	SSA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NCR	NER	OFR	CWR	SWR	SER	IS	OS	U/K	TOTAL
AIDS	33	71	11	2	3	2	15	-	-	-	3	3	-	1	2	-	-	-	4	150
Amoebiasis	-	2	-	1	-	1	-	-	-	2	1	-	-	-	-	-	-	-	-	7
Arboviral Inf. (NOS)	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1
Brucellosis	-	-	-	-	-	-	-	-	-	-	2	2	-	-	-	-	-	-	-	4
Campylobacter inf.	65	62	199	107	113	135	100	23	10	20	68	79	9	10	5	7	19	1	10	1042
Chlamydia inf.	1	36	2	5	3	-	-	-	25	6	50	29	2	-	2	1	-	-	1	163
Cholera	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Encephalitis (NOS)	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	1
Food Poisoning (NOS)	1	-	-	-	5	1	3	-	-	-	-	-	-	1	10	-	-	-	-	21
Genital herpes	1	284	-	12	5	15	2	2	15	12	56	34	6	5	1	-	2	-	2	454
Giardiasis	13	18	42	17	21	23	22	24	-	24	137	26	6	6	-	2	1	-	4	386
Gonorrhoea	9	150	4	13	5	3	1	4	1	10	25	18	16	4	1	-	-	-	3	267
Hepatitis A	1	2	-	-	2	1	5	-	-	1	1	1	-	-	2	-	-	-	-	16
Hepatitis B	5	18	4	45	11	3	3	5	3	4	24	19	48	3	3	1	2	-	-	201
Hepatitis C	2	-	-	-	2	-	1	-	-	-	1	1	-	-	-	-	-	-	-	7
Hepatitis unspc.	-	-	-	-	-	-	-	-	-	1	-	1	-	1	-	-	-	-	-	3
Hydatid disease	-	-	-	-	-	-	-	-	-	-	3	-	-	1	-	-	-	-	-	4
Infantile diarr. (NOS)	-	-	-	3	4	15	-	-	3	1	35	5	2	-	-	-	-	-	-	68
Legionnaires' dis.	-	1	4	3	1	-	4	-	1	2	1	-	-	1	-	1	2	-	-	21
Leprosy	1	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3
Leptospirosis	-	1	1	-	3	-	-	-	4	1	4	4	-	1	2	3	2	-	3	29
Malaria	9	17	2	3	7	2	33	3	4	7	2	4	1	4	6	1	-	1	11	117
Measles	-	-	17	2	2	1	1	1	-	3	27	3	-	-	-	-	-	-	1	58
Meningococcal inf.	1	1	9	6	4	4	3	1	-	4	9	9	4	2	-	-	-	-	1	58
Nonspecific urethritis	-	682	2	114	3	1	2	1	85	62	11	7	3	-	1	-	1	-	5	980
Pertussis	15	1	8	10	8	13	7	10	-	3	9	15	4	3	-	-	1	-	1	108
Q Fever	-	1	-	-	2	-	-	1	1	-	11	8	3	19	-	-	1	-	1	48
Ross River virus	1	4	1	-	-	1	2	1	3	26	81	39	10	7	20	-	12	1	4	213
Rubella	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1
Salmonella inf.	69	49	77	113	103	78	116	22	32	42	67	50	31	16	22	22	15	-	12	936
Shigella inf.	3	13	2	8	3	2	5	2	3	2	17	10	8	2	1	-	6	1	-	88
Syphilis	10	72	7	21	1	-	2	-	6	8	12	10	60	-	2	-	-	-	3	214
Trachoma	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1
Tuberculosis	44	47	31	33	34	6	19	2	7	8	1	8	3	2	1	1	1	-	4	252
Typhoid & paratyphoid	1	6	1	1	1	-	3	-	2	1	5	-	-	-	-	-	1	-	-	22
Vibrio																				
Parahaemolyticus	-	-	1	1	-	1	-	-	-	2	-	-	-	-	-	-	-	-	-	5
Vibrio Vulnificus	-	-	-	-	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	2
Yersinia inf.	12	5	5	12	6	2	13	1	1	-	15	3	2	-	-	-	2	-	-	79

*Abbreviations used in this Bulletin:*

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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 the disease onset date and not simply the date of notification or receipt of such notification.

# NEWS AND COMMENT

## CENTRAL OFFICE MOVE

**T**he Central Administration of the NSW Department of Health will move to its new North Sydney headquarters in October. The Public Health Division will be located on the seventh floor of the building at 73 Miller St, North Sydney 2060. The postal address is:

Locked Bag  
PO Box 961  
North Sydney NSW 2059

Please note the following telephone numbers:

Dr Sue Morey, Chief Health Officer	(02) 391 9181
Dr Gavin Frost, Deputy Chief Health Officer	(02) 391 9180
Dr George Rubin, Director, Epidemiology	(02) 391 9191
Ms Ruth Cotton, Director, AIDS Bureau	(02) 391 9235
Dr Noel Wilton, Director, Mental Health	(02) 391 9299
Dr Michael MacEvoy, Director, Drug Offensive	(02) 391 9288

## NEW ADDITION TO 'BULLETIN'

**P**rofessor James Lawson, well known to many of you, has been reviewing the public health literature and preparing abstracts of the more interesting articles for some years now. Previously these abstracts were sent out from the Department of Health as circulars. From this month we will be publishing in each issue selected abstracts from Professor Lawson's files. Please send your comments on the utility of these abstracts to the editor.

## COUNTRY PUBLIC HEALTH UNITS MEET

**C**ountry Public Health Unit (PHU) Directors converged on Sydney on Friday, August 17, 1990 with the following meeting objectives:

- 1 To identify common approaches as well as differences in the developing Country PHUs to access the best ideas from a pool rather than each Region starting completely from scratch.
- 2 To form an advocacy group for specific rural issues which may otherwise get lost in a combined Country/Metropolitan Forum.
- 3 To identify areas of specific interest/expertise which we might agree to encourage in one Region but with the benefits eventually being shared by all Regions.

The meeting commenced with a brief outline of the organisational structure of each Country PHU. The widely different approaches being taken confirmed the importance of meeting to explore the potential for a more uniform structure.

By meeting in Sydney it was possible to have direct access to a number of Central Office staff. Early in the day the meeting provided George Rubin with an outline of objectives and then at the close of the meeting he received immediate feedback on the outcome of discussions.

The minutes record wide ranging discussion including:

- Support for the change of status of Health Surveyors to Environmental Health Officers
- Commendation of the Public Health Bulletin and the value of providing locally relevant inserts
- Progress in the preparation of Toxicological profiles and the value of sharing information between adjacent Regions
- The importance of including Health Promotion within the Public Health Unit framework, and
- Sharing of some of the difficulties in implementing the new Infectious Disease Response Protocols in rural areas.

The Country PHU Directors supported the continuing presence of a rural representative on the Infectious Disease Advisory Committee. Stephen Christley as a current member proposed that the position should rotate on an annual basis.

Significant differences in the Administration of regions and Area Health Services were identified as further justification for country PHU Directors meeting separately. The Chief Health Officer has been approached for formal support for these meetings to continue on a quarterly basis.

Two key messages were conveyed to George Rubin at the end of the meeting:

- Positive support for the re-instatement of Public Health on the agenda of the Department and for the initiative leading to the establishment of Public Health Units.
- The need for the Department to support locally identified priorities rather than impose programs which consume limited resources and prevent Country PHUs from addressing the basic health needs of country people.

The Country PHU Directors have offered the proposed quarterly meeting as a useful forum for the Department to canvass proposals and for genuine two-way consultation.

# NEWS AND COMMENT

## NYNGAN FLOOD FOLLOW-UP

In September we reported some of the health effects of the Nyngan floods. Surveillance of diseases in people normally living in Nyngan continued until May 31. General practitioners in Dubbo and Nyngan and staff at local hospitals collected data on the age, sex and condition of Nyngan residents treated.

Sixteen doctors returned information on Nyngan patients from early May. Some GPs and the Nyngan Hospital were able to provide data on consultations from April 16, 1990, when the flood occurred. Information on patients up to May 10 was unavailable from the one GP who saw most Nyngan patients in Dubbo. Figure 2 shows the breakdown of presenting complaints in Nyngan residents to May 31, 1990. Figure 3 shows presenting complaints as a percentage of the total.

Lacerations were most prominent just before the flood when flood levees were being reinforced. Skin infections were pronounced soon after the flood. Respiratory tract problems, including infections and asthma, increased in mid-May. However, this may have been associated with cooler weather. Vaccinations were common, probably reflecting the Department of Health's recommendation to residents to update their tetanus vaccinations. Some people also had hepatitis A immunoglobulin.

Caution is urged when interpreting these data. Patchy reporting, the lack of pre-flood data and of a comparison group limit its usefulness. However, post-flood surveillance was useful for detecting major outbreaks of disease such as gastrointestinal infection. None was detected. Further epidemiological studies will be required to detect more subtle health effects.

## TRAVEL MEDICINE ADVICE

Travel medicine advice can be obtained by staff of all Public Health Units accessing the MASTA system (see PHB 1990;1(6):18).

The Centers for Disease Control in Atlanta, Georgia provide a 24 hour automated telephone information service for overseas travellers. Information options include malaria prophylaxis, immunisation for children under two years of age, advice for pregnant travellers and reports of current disease outbreaks. You can access this service by dialling 0011-1-404-332-4559.

## MOSQUITO CONTROL TRAINING

A course of instruction and practical training covering mosquito-borne disease in south-eastern Australia, mosquito biology and ecology, surveillance and identification, and mosquito control technologies will be held in Leeton, NSW at the Staff Development Centre from Monday December 3 to Thursday December 6, 1990.

The course is especially designed to meet the needs of Health Surveyors and Environmental Officers, Service Hygiene and Government Quarantine Inspectors, and others responsible for control of pest and/or vector mosquitos in South-eastern Australia.

The course will be presented by Dr Richard Russell, Head of the University of Sydney's Medical Entomology Unit at Westmead Hospital in collaboration with Mr Terry Carvan, Senior Health Surveyor, South West Health Region of the NSW Department of Health.

### PUBLIC HEALTH EDITORIAL STAFF

The Bulletin's editorial advisory panel is as follows:

Dr Sue Morey, Chief Health Officer, Department of Health; Professor Stephen Leeder, Professor of Community Medicine, University of Sydney; Professor Geoffrey Berry, Professor of Epidemiology & Biostatistics, University of Sydney; Dr Robert Reznik, Acting Director, Department of Community Medicine, Royal Prince Alfred Hospital; Professor Ian Webster, Professor of Community Medicine, University of NSW; Dr Christine Bennett, Acting Associate Director, Service Development, Department of Health; Dr Michael Frommer, Epidemiologist, Epidemiology & Health Services Evaluation Branch; Ms Jane Hall, Research Officer, Department of Community Medicine, Westmead Hospital; and Mr Michael Ward, Manager, Health Promotions Unit, Department of Health.

The editor is Dr George Rubin, Director, Epidemiology and Health Services Evaluation Branch, Department of Health, NSW.

Design and Production — Health Public Affairs Unit, Department of Health, NSW.

Please send your articles, news, comments or letters to Dr George Rubin — Locked Bag, 961, North Sydney NSW 2059 or Fax (02) 391 9293.

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