



## NYNGAN FLOOD LESSON

In April this year, heavy rains fell throughout northern and western New South Wales, causing flooding of the NSW and Queensland inland river systems. The town of Nyngan (population approx. 2,500), located on the Bogan River 165 kilometres north west of Dubbo, was particularly affected because of its flat terrain. Previous flooding of the town occurred in the 1950s but the construction of levee banks prevented this from recurring, even after heavy rains in 1976.

However, a massive local effort to prevent submersion of the town failed when the levees broke on April 23, 1990. Water up to one metre deep entered over 95% of houses, forcing helicopter evacuation of the entire population to Dubbo; only emergency workers and a handful of residents who refused to leave remained in Nyngan. We estimated that 1,500 residents of Nyngan were accommodated mostly in private houses and motels in Dubbo (population 30,135).

The flood waters, containing mud and silt, submerged pumps at the sewage treatment works and the town's reticulated water supply depot, disrupted pipes and cut power and communication lines. Apart from rainwater tanks, the town was left without potable water, sewage or other services. Food and organic matter remained unrefrigerated in both commercial and residential premises. Houses and shops sustained extensive damage to their contents. The flood waters dislodged large freezers in commercial premises, causing them to spill their contents. A large number of animals, including dogs, horses and pigs, were left untended. There were early reports of animal carcasses and sewage littering the streets.

Emergency relief and restoration efforts were rapidly implemented. A group of police, ambulance officers and Bogan Shire staff who had remained in Nyngan started salvage operations. A town co-ordinating committee was formed to establish priorities. On April 28 the Orana and Far West Regional Director of Health directed that adequate potable water and sewage and waste disposal systems be provided to the town, putrescible material be removed from shops and houses, houses and public places be cleaned, birds and animals removed, and insects controlled. A temporary garbage depot was established

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## Nyngan Flood Lesson

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several kilometres from the town. A Public Health Medicine Registrar (JM) was despatched to Nyngan by the Department of Health on April 28 to assist with the maintenance of public health. Finally, an Administrator, appointed by the Premier on May 1, arrived to direct reconstruction efforts.

Measures were rapidly implemented to restore essential services and supplies. By May 3, a fleet of buses was organised to bring back most of the townspeople during daylight over four days, so that they could assess damage to their property and remove personal effects for cleaning and safekeeping. Nyngan residents were asked to indicate their needs so that donated aid materials could be appropriately distributed. All Nyngan residents returning to the town were offered tetanus immunisation by the Department of Health's Orana and Far West Regional Office at the Disaster Recovery Centre in Dubbo, and by staff at Nyngan Hospital. Emergency workers were encouraged to update their tetanus immunisation.

The Regional Office of the Department monitored the mosquito population in the district, setting mosquito traps in Nyngan, nearby towns and the Macquarie Marshes to the north-west. Initial tests on May 7 did not find significant numbers of potential arbovirus vectors.

Citizens of NSW were quick to offer assistance. Donated items of all kinds, ranging from clothes to toys, streamed into Dubbo for the flood victims. Citizens from a nearby town offered to wash all the dirty linen in the town and to provide 1,000 pairs of rubber gloves. A group of electrical technicians volunteered to check the safety of electrical appliances in houses free of charge.

Before residents were permitted to return permanently to their homes, the houses were inspected by health surveyors to assess suitability for human habitation.

### FLOOD-RELATED ILLNESS

Anecdotal reports of skin infections in Nyngan residents prompted us to study whether these were increased among flood victims. We examined Dubbo Base Hospital Casualty Department attendance records for the period April 24 to May 5. We selected people with infections of skin, and for comparison people with infections of the gastro-intestinal tract (including abdominal pain), and the upper respiratory tract (including 'viral illnesses'). The distribution of casualty attendances for these conditions by place of residence is given in Table 1.

TABLE 1

PLACE OF RESIDENCE OF PEOPLE ATTENDING DUBBO BASE HOSPITAL CASUALTY WITH SYMPTOMS OF SKIN, RESPIRATORY AND GASTRO-INTESTINAL INFECTIONS: April 24 to May 5, 1990

TOWN	SI (rate)	RI (rate)	GI (rate)	Total (rate)
Dubbo	4 (0.1)	17 (0.6)	21 (0.7)	42 (1.4)
Nyngan	8 (5.3)	2 (1.3)	3 (2.0)	13 (8.7)
Other/Unknown	2	6	9	17
<b>Total</b>	<b>14</b>	<b>25</b>	<b>33</b>	<b>72</b>

SI = symptoms of skin infection  
 RI = symptoms of respiratory tract infection or "viral illness"  
 GI = symptoms of gastro-intestinal infection or abdominal pain  
 rate = cases per 1000 based on estimated population of Nyngan residents in Dubbo and of Dubbo residents in Dubbo.

People with skin infections were more likely to have lived in Nyngan than Dubbo compared with people with respiratory infections (odds ratio 17.0, 95% CL 2.0 to 199.3) or people with gastro-intestinal infections (odds ratio 14.0, 95% CL 2.0 to 110.4). People with respiratory infection were just as likely to have lived in Nyngan or Dubbo as people with gastro-intestinal infections (odds ratio 0.8, 95% CL 0.1 to 8.1).

These results suggest that people living in Nyngan at the time of the floods were more likely to suffer skin infections than people living away from the flooded areas. The data, however, should be interpreted cautiously, as Nyngan residents were dislocated from their usual general practitioners, and they were therefore more likely to seek care from the hospital than were Dubbo residents. Nevertheless, the data support the view that the prompt evacuation of the population from the flooded town and the rapid implementation of public health measures prevented further flood-related infections.

Continuing surveillance of diseases in people normally living in Nyngan continued until May 31. A report on these data will appear in a forthcoming issue of the Bulletin.

### EDITORIAL NOTE

Flooding is estimated to cause 40 per cent of the world's natural disasters. As more people occupy flood-prone areas, we can continue to expect flood-related disasters. Worldwide, the major cause of death from flooding is drowning. In non-industrialised countries, outbreaks of certain infectious diseases have been documented following floods, including leptospirosis, malaria, yellow fever and typhoid fever. Environmental contamination from chemical stores affected by floods has occurred. In addition psychological illness has been found among flood victims up to five years after the event<sup>1</sup>.

Illness can be prevented in these circumstances by ensuring contamination-free food and water supplies, by providing facilities for the safe disposal of waste, and if necessary, by controlling insect vectors.

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*We are grateful for the assistance of Robert Arthurson MBBS MBA,  
 and Bob Taylor, Orana and Far West Regional Office, Department  
 of Health, NSW.*

1. French JG and Holt KW. Floods, in: *The Public Health Consequences of Disasters 1989*. CDC Monograph. US Department of Health and Human Services, Public Health Service, Centres for Disease Control, Atlanta, Georgia.



## IMMUNISATION AGAINST RABIES

The Epidemiology and Health Services Evaluation Branch, Department of Health, NSW, receives numerous inquiries about protection against rabies, mainly from medical practitioners consulted by travellers who have been bitten by animals in parts of the world where rabies is endemic. The Branch, which has responsibility for authorising the distribution of rabies hyperimmune globulin and vaccine for post-exposure prophylaxis, follows current National Health and Medical Research Council recommendations<sup>1</sup>.

Information on *pre-exposure prophylaxis* is available through Public Health Units, general practitioners and travellers' medical services. Travellers should be advised of the hazards of encountering animals in countries where rabies is endemic, and pre-exposure immunisation should be considered for veterinarians and other workers likely to come into contact with rabies virus or rabid animals.

*Post-exposure prophylaxis* has two components — the local treatment of wounds and immunisation. All potentially rabies-prone bite wounds should be washed immediately with soap and water. Thorough simple cleansing has been shown to be effective in reducing the risk of rabies.

*Post-exposure immunisation* is presently funded by the New South Wales Department of Health. Medical practitioners seeking authorisation to obtain rabies hyperimmune globulin and vaccine should contact the Manager, Infectious Diseases Section, Epidemiology and Health Services Evaluation Branch (phone (02) 217 6165). Arrangements are then made for the hyperimmune globulin and vaccine to be delivered by courier from the Commonwealth Serum Laboratories to the doctor.

Criteria for authorising the hyperimmune globulin and vaccine for *post-exposure prophylaxis* are as follows:

- The doctor requesting the hyperimmune globulin and vaccine states that the patient requiring the injections has been bitten by a mammal; and
- The animal bite occurred in a geographical location where the animal could possibly have been rabid. Rabies is epidemic or endemic in most parts of the world, *except* Oceania, Melanesia, Japan, Taiwan, the UK, Ireland and Sweden. Papua New Guinea is currently rabies-free. Recent advice promulgated by the NHMRC indicates that Balinese monkeys are rabies-free<sup>2</sup>.

The time period between the alleged bite and the authorisation of the hyperimmune globulin and vaccine is of little practical relevance as the incubation period for rabies can be up to two years<sup>3</sup>.

In practice the hyperimmune globulin and vaccine are authorised for administration to anyone allegedly bitten by a furry animal in any part of the world *other than* those listed above. Usually it is impossible to determine the likelihood that the animal which bit an individual patient was potentially rabid.

A post-exposure prophylactic course usually consists of one injection of hyperimmune globulin (cost: \$489.72) and six injections of human diploid cell rabies vaccine (\$167.00 each). The cost of rabies post-exposure prophylaxis is \$1491.72 for a full course. The hyperimmune globulin is given on day 0, along with the first dose of vaccine. Subsequent vaccine doses are administered intramuscularly on days 3, 7, 14, 28 and 90 after the initial immunisation.

During the 1989 calendar year, 136 courses of post-exposure rabies prophylaxis were authorised.

Since April 1990 detailed data have been collected on all requests, using a standardised data-collection form. Over this period, the Epidemiology and Health Services Evaluation Branch received 15 requests for rabies prophylaxis (proportionately much fewer than 1989). Thirteen of the requests were authorised. One of the two requests denied was for a Balinese-monkey bite, and the other was a request for pre-exposure prophylaxis. Three of the 13 requests authorised were for non-residents of Australia who had been bitten while travelling in another country on their way to an Australian visit.

The NHMRC draws attention to the importance of local treatment of wounds as well as immunisation in the post-exposure prophylaxis.

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1. National Health and Medical Research Council. *Immunisation Procedures*, 3rd edition. Australian Government Publishing Service, Canberra, 1986.  
2. National Health and Medical Research Council. *Report of the 108th Session*, Canberra, November 1989. Australian Government Publishing Service, Canberra, 1990.  
3. Christie AB. *Infectious Disease*. Churchill Livingstone. Edinburgh, 1987.

## MORTALITY TRENDS

The Department has obtained a complete record of all deaths of New South Wales residents which occurred during the period January 1, 1985 to December 31, 1987<sup>1</sup>. This provides a more accurate picture of mortality in the state than death-register data because it records cases by year of death (rather than year of registration), and because it includes NSW residents who died interstate and excludes non-residents who died while visiting NSW.

Comparison of three-year-average mortality figures for 1985-87 with mortality during the 1980-1982 period highlights the following major changes.

- Since 1980-82 mortality rates have decreased at all ages (except for males aged 30-34 and to a lesser extent than between 1975-77 and 1980-82).
- The mortality decline in NSW has been less than that in other states and territories, except Tasmania. This has widened the already-existing disparity between NSW and the rest of the country.
- Of all the Areas and Regions, the Central Sydney Area and the Orana and Far West Region continue to have the highest mortality. The Northern Sydney Area continues to have the lowest mortality in the state.
- Expectation of life at birth has risen by 1.5 years in males (to 72.4 years) and by 0.9 years in females (to 79.0 years). For the first time since 1901 the increase in life expectancy for males has exceeded that for females.
- Changes in the leading causes of death observed between 1975-77 and 1980-82 have continued in the latest five-year period. The contribution of heart disease to overall mortality has declined, especially among males, while malignant neoplasms account for an increased proportion of deaths. The rapid rise in lung-cancer deaths among females presents a major challenge to the public health system. There are increased death rates from chronic respiratory conditions, drug overdose and AIDS.

Further information is available from the author (telephone (02) 219 7423).

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1. Department of Health, NSW. *Health Services Information Bulletin* No. 14. Mortality in New South Wales. State Health Publication No. 90-13.



# SENTINEL MONITORING OF INFLUENZA

Influenza monitoring began on June 4, 1990, with collection of information on the patients of 24 participating general practitioners in the Sydney metropolitan area. This article outlines provisional information relating to the period June 4 to July 8, 1990. The occurrence of influenza is based both on the general practitioner's clinical assessment of the patient having an influenza-like illness and on the application of defined criteria to the patient's symptoms.

All patients who present to participating GPs with an initial complaint of an influenza-like illness enter the study. The criteria for clinical diagnosis of influenza published in the International Classification of Health Problems in Primary Care, 2nd edition [ICHPPC-2]<sup>1</sup> are then applied to the study subjects. 'Influenza-like illness' was deliberately not defined in the design of the study, but the ICHPPC-2 criteria are not applied to patients presenting with symptoms unrelated to acute respiratory tract infections. Subjects are classified as having influenza (as defined by ICHPPC-2) if at least four of the following eight criteria are fulfilled:

- 1 sudden onset (within 12 hours)
- 2 cough
- 3 rigors or chills
- 4 fever
- 5 prostration and weakness
- 6 myalgia, widespread aches and pains
- 7 no significant respiratory signs other than redness of nasal mucous membrane and throat
- 8 influenza in close contacts.

The proportions of all general-practitioner consultations that relate to both influenza-like illness and ICHPPC-2 defined influenza are shown in Figure 1. These proportions are expressed as the number of cases per 100 consultations.

## EDITORIAL COMMENT

No previous studies of the incidence of influenza in the Sydney metropolitan area have been attempted. Therefore a comparison of the current incidence of influenza relative to previous periods is not possible. By July 16, 1990, information on 12,964 consultations had been processed. The proportion of general-practitioner consultations relating to influenza-like illness is only 4.7%, while the proportion fulfilling ICHPPC-2 criteria is 2.5%.

Of the people presenting with influenza-like illness who had been immunised this year against influenza, 46% were below the NHMRC recommended age of 65 years. This does not take into account other medical conditions that could have made immunisation advisable.

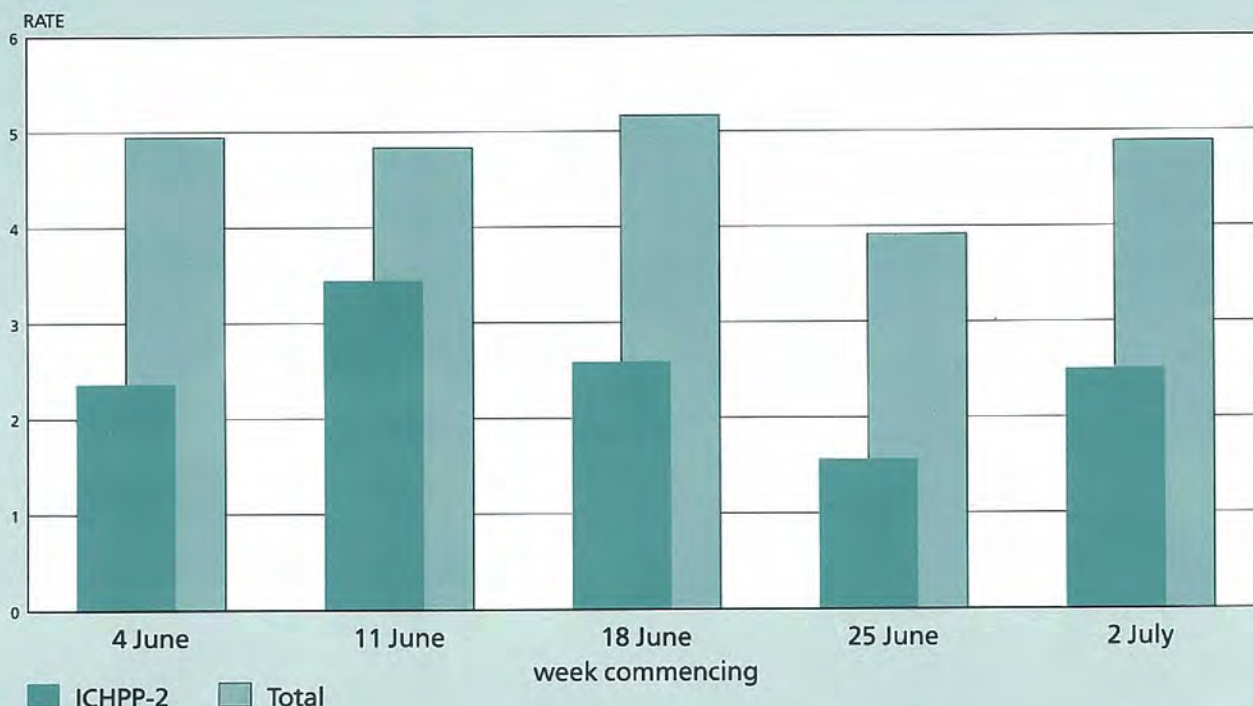
Four-weekly reports of data collected in this study will appear in future issues of the *Public Health Bulletin*.

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1. World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) Classification Committee. *International classification of health problems in primary care*, 2nd ed. Oxford University Press, Oxford, 1983.

FIGURE 1

RATE OF INFLUENZA-LIKE ILLNESS





# INFECTIOUS DISEASES

## NOTIFICATIONS

Tables 1 and 2 list New South Wales infectious disease notifications for reporting periods 5 and 6 (April 22-June 17, 1990). Attention is drawn to the notifications of arbovirus diseases, sexually transmitted diseases, measles and malaria.

**ARBOVIRUS** A large number of Ross River Fever notifications have been received in reporting periods 5 and 6. This is more than for any comparable period over the past five years. The increase is due to an increased number of notifications received from private laboratories. On a cumulative basis, the number of notifications has decreased by approximately 46% compared to 1989. The greatest proportion of notifications in 1990 come from the North Coast Region (33%), New England Region (21%), Hunter (12%) and South West Region (10%). This is in contrast to 1989 where, due to the outbreak in the South West Region, 44% of all cases originated in that area, while 13% occurred in the North Coast and 10% in the New England Region.

**SEXUALLY TRANSMITTED DISEASES** Increases in reported cases of non-specific urethritis go against the general trend of decreased notifications for STDs. The difference is not, however, statistically significant (student t-test).

**MEASLES** Two clusters of this vaccine-preventable condition were notified — one in the North Coast Region and the other in the Southern Sydney Health Area. The latter is part of a local epidemic centred on three schools in the Engadine area. In the face of continued measles cases, an immunisation catch-up campaign is presently being undertaken. This particular local government area had not benefited from the activities associated with the Bicentennial Measles Campaign.

**MALARIA** The June 1990 issue of the *Public Health Bulletin* commented on the increased frequency of malaria notifications, a trend which has continued into reporting periods 5 and 6. There are several possible explanatory factors:

- up to 40% of cases have not taken prophylaxis treatment as prescribed.
- drug resistance has been an increasing problem among *Plasmodium falciparum* isolates, and the trend for *P. falciparum* to dominate in some parts of the world (54% of cases in Africa). Of *P. falciparum* cases registered by the NSW Malaria Registry, 37% came from Papua and New Guinea, 11% from Nigeria and 7% each from Solomon Islands, Thailand and Ghana.

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

TABLE 1

## INFECTIOUS DISEASE NOTIFICATIONS, NSW

CONDITION	Number of Cases Notified			
	Period		Cumulative	
	22-04-90 to 16-06-90	22-04-89 to 16-06-89	1990	1989
AIDS	26	44	150	138
Amoebiasis	—	3	4	4
Ancylostomiasis	—	—	—	—
Anthrax	—	—	—	—
Arboviral infection (NOS)	—	—	1	—
Brucellosis	—	1	3	1
Campylobacter infection	287	309	826	1004
Chancroid	—	—	—	—
Chlamydia infection (NOS)	28	N/A	92	N/A
Cholera	—	—	1	—
Congenital rubella syndrome	—	—	—	—
Diphtheria	—	—	—	—
Donovanosis	—	—	—	—
Encephalitis (NOS)	—	—	—	—
Food poisoning (NOS)	3	—	10	4
Genital herpes	112	151	294	374
Giardiasis	81	151	298	408
Gonococcal ophthalmia neo.	—	1	—	1
Gonorrhoea	63	75	213	327
Hepatitis A	5	1	13	38
Hepatitis B	60	101	158	250
Hepatitis C	3	—	6	—
Hepatitis unspecified	—	5	2	6
HIV	N/A	N/A	N/A	N/A
Hydatid disease	—	1	—	1
Infantile diarrhoea (NOS)	10	52	42	176
Legionnaires' disease	1	9	16	34
Leprosy	2	—	5	7
Leptospirosis	9	3	26	25
Lymphogranuloma venereum	—	—	—	—
Malaria	20	13	86	30
Measles	25	5	40	10
Meningococcal infection	12	12	27	22
Non specific urethritis	257	208	687	871
Ornithosis	—	2	—	4
Pertussis	12	11	97	32
Plague	—	—	—	—
Poliomyelitis	—	—	—	—
Q fever	19	16	74	58
Rabies	—	—	—	—
Ross River fever	101	55	188	350
Salmonella infection	182	182	742	775
Shigella infection	9	18	65	48
Syphilis	55	69	147	171
Tetanus	—	—	—	—
Trachoma	—	—	1	—
Tuberculosis	59	82	194	237
Typhoid & paratyphoid	4	1	14	13
Typhus	—	—	—	—
Vibrio infection (NOS)	3	1	8	7
Viral haemorrhagic fevers	—	—	—	—
Yellow fever	—	—	—	—
Yersinia infection	13	20	64	55

NOS - Not Otherwise Specified



**TABLE 2**

**INFECTIOUS DISEASE NOTIFICATIONS,  
BY HEALTH AREA & REGION  
22 April-16 June 1990**

DISEASES	CSA	ESA	SSA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NCR	NER	OFR	CWR	SWR	SER	VIC	QLD	ACT	U/K	OS	TOTAL	
AIDS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	26	-	26
Campylobacter inf.	11	9	60	34	35	34	20	6	2	3	13	40	4	2	-	3	1	1	5	3	1	-	287
Chlamydia inf.	-	7	-	-	-	-	-	-	-	1	4	10	1	-	-	-	-	-	-	-	4	-	27
Chlamydia Psittaci	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1
Food Poisoning (NOS)	-	-	-	-	1	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3
Genital herpes	-	84	-	1	-	-	-	-	-	6	10	10	1	-	-	-	-	-	-	-	-	-	112
Giardiasis	2	2	4	3	4	5	2	6	-	5	39	3	-	2	-	-	-	-	-	-	4	-	81
Gonorrhoea	4	41	-	3	1	-	1	-	-	1	5	2	3	1	-	-	-	-	-	-	1	-	63
Hepatitis A	1	-	-	-	-	1	2	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	5
Hepatitis B	3	6	2	22	3	2	-	1	-	-	3	8	9	-	-	1	-	-	-	-	-	-	60
Hepatitis C	-	-	-	-	1	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-	-	-	3
Infant diarr. (NOS)	-	-	-	-	-	7	-	-	-	-	-	1	2	-	-	-	-	-	-	-	-	-	10
Legionnaires' dis.	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Leprosy	-	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Leptospirosis	-	-	-	-	1	-	-	-	1	-	3	-	-	-	2	1	-	-	-	-	1	-	9
Malaria	-	2	-	2	1	-	3	-	1	3	1	-	-	1	1	1	-	-	-	-	4	-	20
Measles	-	-	10	1	-	1	-	-	-	-	11	2	-	-	-	-	-	-	-	-	-	-	25
Meningococcal inf.	2	-	-	1	-	-	-	-	-	-	5	3	1	-	-	-	-	-	-	-	-	-	12
Nonspecific urethritis	-	205	1	29	2	-	-	-	1	17	-	1	-	-	1	-	-	-	-	-	-	-	257
Pertussis	-	-	-	-	2	-	-	2	-	1	1	5	-	-	-	-	-	-	-	1	-	-	12
Q Fever	-	-	-	-	-	-	1	-	1	7	-	-	1	6	2	1	-	-	-	-	-	-	19
Ross River virus	-	3	1	-	-	-	-	1	1	16	38	28	3	-	3	-	1	3	1	2	-	-	101
Salmonella inf.	12	8	22	25	15	20	23	4	5	6	8	10	4	4	5	6	-	1	3	1	-	-	182
Shigella inf.	-	-	-	-	-	1	2	-	-	-	3	1	-	1	-	-	-	-	-	-	1	-	9
Syphilis	2	25	4	6	-	-	1	-	-	1	2	3	9	-	1	-	-	-	-	-	1	-	55
Tuberculosis	14	10	7	8	8	1	2	-	3	3	-	1	2	-	-	-	-	-	-	-	-	-	59
Typhoid & paratyphoid	-	-	-	-	1	-	1	-	-	-	1	-	-	-	-	-	-	-	-	-	1	-	4
Vibrio Parahaemolyticus	-	-	-	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	2
Vibrio Spp	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1
Yersinia inf.	2	1	1	1	-	1	3	-	-	-	3	-	-	-	-	-	-	-	-	-	1	-	13

**TABLE 3**

**INFECTIOUS DISEASE NOTIFICATIONS  
BY HEALTH AREA AND REGION  
1 Jan-16 June, 1990**

DISEASES	CSA	ESA	SSA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NCR	NER	OFR	CWR	SWR	SER	VIC	QLD	SA	TAS	ACT	U/K	OS	TOTAL	
AIDS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	150	-	150	
Amoebiasis	-	2	-	-	-	1	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	4	
Arboviral inf. (NOS)	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	
Brucellosis	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	3	
Campylobacter inf.	46	24	158	92	100	114	88	19	8	18	42	70	7	8	5	4	1	2	-	1	9	8	2	826	
Chlamydia inf.	-	19	1	3	1	-	-	-	-	4	25	27	3	-	1	-	-	-	-	-	-	5	-	89	
Chlamydia Psittaci	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	2	
Cholera	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	
Food Poisoning (NOS)	-	-	-	5	1	3	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	10	
Genital herpes	-	201	-	8	-	3	1	2	-	12	32	31	1	2	-	-	-	-	-	-	-	1	-	294	
Giardiasis	5	9	26	16	16	19	20	15	-	19	116	17	5	6	-	1	-	1	-	-	-	7	-	298	
Gonorrhoea	7	127	2	8	3	-	1	2	-	9	21	16	11	4	1	-	-	-	-	-	-	1	-	213	
Hepatitis A	1	1	-	-	2	1	4	-	-	-	1	-	-	2	1	-	-	-	-	-	-	-	-	13	
Hepatitis B	5	22	3	40	9	2	1	5	1	4	11	15	34	3	2	1	-	-	-	-	-	-	-	158	
Hepatitis C	1	-	-	-	2	-	1	-	-	-	-	2	-	-	-	-	-	-	-	-	-	-	-	6	
Hepatitis - unspec.	-	-	-	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-	-	-	-	-	-	2	
Infant diarr. (NOS)	-	-	-	2	4	16	-	-	2	1	13	3	1	-	-	-	-	-	-	-	-	-	-	42	
Legionnaires' dis.	-	1	4	2	2	-	4	-	-	-	-	-	-	1	-	-	-	-	-	-	2	-	-	16	
Leprosy	1	1	-	2	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5	
Leptospirosis	-	-	1	-	3	-	-	-	3	1	5	3	-	1	3	2	1	-	-	1	-	2	-	26	
Malaria	7	14	-	2	4	2	22	1	3	6	2	2	1	4	3	1	-	-	-	-	-	11	1	86	
Measles	-	-	12	2	1	1	1	-	-	19	2	-	-	1	-	-	-	-	-	-	-	-	-	40	
Meningococcal inf.	2	-	2	4	1	-	1	-	-	1	8	5	2	1	-	-	-	-	-	-	-	-	-	27	
Nonspecific urethritis	-	521	2	88	2	1	2	-	2	56	4	4	-	1	-	-	-	1	-	-	-	3	-	687	
Pertussis	14	1	5	9	7	11	6	10	-	3	7	15	4	3	-	1	-	-	-	-	-	1	-	97	
Q Fever	-	2	-	-	-	-	1	-	1	1	14	8	5	35	4	1	-	1	-	-	-	1	-	74	
Ross River virus	1	4	1	-	-	1	2	1	2	23	63	40	7	7	18	-	1	5	-	4	2	5	1	188	
Rubella	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	1	
Salmonella inf.	54	30	59	89	76	64	93	17	27	28	61	44	23	15	18	20	5	5	-	-	5	9	-	742	
Shigella inf.	3	1	2	7	3	2	6	2	2	-	15	6	8	3	1	-	2	-	-	-	-	-	1	1	65
Syphilis	8	57	6	15	-	-	2	-	-	5	5	5	41	-	2	-	-	-	-	-	-	1	-	147	
Trachoma	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	1	
Tuberculosis	41	33	25	27	22	4	13	2	6	6	1	4	3	1	1	-	1	-	-	-	-	4	-	194	
Typhoid & paratyphoid	1	4	-	-	1	-	2	-	2	1	2	-	-	-	-	-	-	-	-	-	-	1	-	14	
Vibrio Parahaemolyticus	-	-	1	1	-	1	-	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	5	
Vibrio Spp	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	1	
Vibrio Vulnificus	-	-	-	-	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	2	
Yersinia inf.	12	3	5	9	4	2	13	1	1	-	9	1	2	-	-	-	-	-	-	-	1	1	-	64	

Abbreviation Health Area/Region: ACT Australian Capital Territory, CCA Central Coast Health Area, CSA Central Sydney Health Area, CWR Central West Health Region, ESA Eastern Sydney Health Area, HUN Hunter Health Area, ILL Illawarra Health Area, NCR North Coast Health Region, NER New England Health Region, NSA Northern Sydney Health Area, NT Northern Territory, OFR Orana & Far West Health Region, OS Overseas, QLD State of Queensland, SA State of South Australia, SER South East Health Region, SSA Southern Sydney Health Area, SWR South West Health Region, SWS South Western Sydney Health Area, TAS State of Tasmania, VIC State of Victoria, WA State of West Australia, WEN Wentworth Health Area, WSA Western Sydney Health Area, U/K Unknown.

NOS - Not Otherwise Specified



# NEWS AND COMMENT

## BEACH USER SURVEY 1989-90

**D**uring the 1989-90 summer season the Department of Health conducted a Beach User Survey in order to estimate the health risk associated with swimming at Sydney beaches. Preliminary results of this survey were released by the Minister for Health, Mr Peter Collins, on June 4, 1990.

After completion of screening procedures, responses were obtained from 2968 people. Overall, about 24% of respondents reported at least one symptom. Of those who did not swim, 17% reported symptoms. Of those who swam at beaches where the maximum geometric mean coliform count did not exceed 300/100mL ('low pollution'), 27% reported symptoms, while 36% of people who swam at 'high-pollution' beaches (where the count exceeded 300/100mL) reported symptoms.

Compared to non-swimmers, swimmers at 'low pollution' beaches were 1.6 times more likely and swimmers at 'high-pollution' beaches 2.2 times more likely to report selected symptoms. A comprehensive report of this survey is now being compiled by Epidemiology and Health Services Evaluation Branch staff.

## NOTIFIABLE DISEASES LIST REVISED

**A**s foreshadowed in the June 1990 issue of the Public Health Bulletin, the New South Wales Infectious Diseases Advisory Committee has approved the final revision of the list of notifiable diseases.

The list contains some important innovations. Laboratory notification will play an important role in the notification of many conditions. Medical practitioners will be requested to notify only 26 diseases, compared with the current list of 52. Sexually-transmitted diseases, with the exception of syphilis, will be notifiable only by STD clinics, and then only in a form that does not identify the clinic client.

It is hoped that the new disease notification system can be implemented by the end of this year, after extensive consultation with Public Health Units and medical practitioners.

## PROTOCOLS FOR THE MANAGEMENT OF INFECTIOUS DISEASES

**D**raft protocols clarifying steps to be taken for the management of notifiable infectious diseases have been circulated to Public Health Units for comment. The drafts aim to standardise the public health approach to these conditions and to reduce the uncertainty among health professionals about what to do upon learning of the occurrence of these conditions. The finalised protocols will lay out steps to be taken from first notification, contact information, management of cases and their contacts, and other public health measures to be taken.

Please contact Dr Michael Levy or Dr Jeremy McAnulty on (02) 217 6165 for further information or suggestions on the drafts.

## HEPATITIS B VACCINE FOR HEALTH WORKERS

**T**HE Department recognises that some health care personnel work in situations where the potential exposure to hepatitis B is a regular hazard and recommends that all health care establishments identify staff who have regular contact with bodily fluids or tissue from patients, and advise them to receive hepatitis B vaccine. *The importance of completing the course of three injections is emphasised.*

## MANAGEMENT OF HIV IN SURGERY

**G**uidelines for the management of HIV in surgery were released as a Department of Health Circular in July 1990. The Guidelines are the product of extensive consultation involving the Department, members of the Ministerial Advisory Committee on AIDS Strategy and relevant groups representing the medical profession.

The principles upon which the Guidelines are based reflect the Department's commitment to the provision of a safe working environment for health care personnel and voluntary HIV testing with pre- and post-test counselling for patients.

Key points from the Guidelines are as follows:

- surgical procedures pose a low level of risk for transmission of HIV;
- universal infection control procedures are the most effective means of preventing occupational transmission of HIV;
- testing is not a substitute for proper implementation of infection control procedures;



# NEWS AND COMMENT

- pre-operative testing is appropriate where there is a possibility, first, that a given surgical procedure will adversely affect the health of an HIV-infected patient, and second, that the procedure will pose an unnecessary or avoidable risk of HIV infection to surgical personnel;
- HIV-positive patients are entitled to respect for their confidentiality in accordance with normal ethical practice;
- the same single system of identification of biohazards should be used as for all infectious diseases.

The Guidelines provide health administrators and health-care workers with a framework for the management of surgical patients which should reduce risks associated with occupational exposure to HIV.

Copies of the Guidelines are available from the AIDS Bureau, Department of Health, NSW (phone (02) 217 5747).

## PUBLIC HEALTH UNIT MEETING

**T**he second meeting of NSW Public Health Unit staff will be held at Rozelle Hospital on 3 September. The full agenda will include discussion on communications; initiatives in infectious disease, reproductive health, environmental health, chronic disease and injury prevention, and health outcome evaluation; training; the recent report prepared by Health Surveyors; and the neuroblastoma screening program.

## TRAVEL HEALTH SEMINAR

**A** seminar on preventing health problems in overseas travellers will be held at 2:00 pm on 4 September at the Qantas auditorium, George St, Sydney. The session, which is sponsored by Qantas, CSL and MASTA, will include sessions on malaria, dengue, and other topics relevant for travellers and their health advisors. Those interested in attending should contact Ms Sue Jobson on (02) 217 5434.

## TUBERCULOSIS SEMINAR

**O**n Wednesday, October 3, 1990 the Community Health and Anti-Tuberculosis Association will hold a seminar on Tuberculosis in the Conference Room, Wallace Wurth Building, Macquarie Hospital, Wicks Rd, North Ryde. The program, beginning at 9:15 am, includes presentations on the epidemiology and eradication of tuberculosis and on the management of persons who are both Mantoux and HIV positive and young contacts of drug resistant cases. Persons interested in attending should contact Dr Roma Thomson on (02) 953 7475.

## PUBLIC HEALTH MEDICINE REGISTRARS

**O**n September 1 and 3 the Public Health Division of the Department of Health, NSW will advertise four positions for medical graduates interested in pursuing a career in public health medicine. These positions will allow registrars to rotate through selected public health positions over a period of three years as a part of required training for membership of the newly formed Faculty of Public Health Medicine.

## NEW INFORMATION BULLETINS

**T**he Information Centre, Department of Health, NSW, publishes information bulletins on specific topics from time to time. A summary of data from the most recent Bulletin, Mortality in New South Wales 1985 to 1987 (No 14), appears on Page 21 of this issue. Other recent Bulletins include: Child Sexual Assault Centres 1987 Statistics (No 10), AIDS Patients in New South Wales Hospitals, July - December 1987 (No 11), Nursing Homes and Nursing Home Type Patients (No 12), Construction of a Relative Stay Index for New South Wales Hospitals by the Use of Diagnosis Related Groups (No 13). Copies can be obtained from the Information Centre (phone (02) 219 7444).

### Correction

*The article "Influenza Monitoring" appearing in the June issue incorrectly attributed Figure 3 to Dr J Watson instead of Dr P Gill.*

### 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 — P.O. Box K110 Haymarket NSW 2000 or Fax (02) 217 5602.

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