



COMMUNICATING WHAT WE DO

Australian authorities could learn valuable lessons from changes to the content and style of public health reports in the United Kingdom in the past three years.

Implementation of the recommendations of the Acheson report into Public Health¹ included the appointment of Directors of Public Health (DsPH) who were asked to produce an annual report on the health of the resident population in their district health authority. Before the introduction of DsPH annual reports, public health reports had been produced by the Medical Officer of Health (MOH) for more than a century. Early MOH reports did improve the health of the general public, but after World War II they became repetitive, stereotyped and failed to add to the improvements in public health achieved by their predecessors, so they were abolished in 1974.

AIMS, CONTENT AND STYLE OF DsPH REPORTS

The aims of DsPH reports are to assess the health of the resident population of their area and promote changes and improvements via the health authority's planning and review processes². The latter aim is accomplished by using DsPH reports for the new task of assessing the health **needs** of the resident population of district health authorities.

A review of the first year's DsPH reports demonstrated considerable variation in their content, style and presentation³. Many concentrated on using the most recently available data for each topic covered. This usually involved consideration of data for a single year only. Topics given prominence included whether the health authority had met World Health Organisation health targets, identification of local inequalities in health, surveys of the population and work conducted with local councils and community groups.

This "where are we now" approach was often replaced in the second year by a "where have we been" approach looking at trends over time from routinely available data. Data for the population of the district health authority were usually compared with those of the corresponding regional health authority and the nation as a whole. Some DsPH produced reports that highlighted only a limited number of subjects which had been investigated locally⁴ rather than employing a greater variety of epidemiological data.

Continued on page 63 ►

Contents

Articles

62 *Communicating What We Do*

64 *Opportunities in the United States*

65 *Catching a Measles Outbreak*

67 *Public Health Abstracts*

Infectious Diseases Notifications

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An important additional source of data made available for the second year of DsPH reports was the Public Health Common Data Set issued by the Department of Health⁵. This publication contained comparable data for different health authorities for a range of demographic data and indicators including "avoidable" deaths and cancer deaths as well as maternal, neonatal, infant and childhood data. Where appropriate, data were presented as standardised mortality ratios and the estimated years lost for residents up to the age of 75 years for related causes of death.

In many cases inferences were made from these data about where services might be expanded, contracted and in some instances investigated. The study of such a wide variety of data allowed DsPH to identify health issues of particular importance to the population of their health authorities so those issues could be addressed in subsequent DsPH reports. A recent guide to the aims, production, publication and uses of future DsPH reports has been published by Middleton et al⁶.

Strengths of DsPH reports³ have included the comprehensive display of demographic, morbidity and mortality data using graphics, photographs, tables and maps. This practice allowed many reports to be accessible to the general public as well as health care personnel. Such an approach is important because clients for the reports include the local health authority, the local council, primary health care providers and community groups. Development of health promotion policy for the population of health authorities was also considered an important topic.

Weaknesses of the reports³ included a lack of critical assessment of data presented, particularly in the application of routine statistics to support inferences. Some reports reduced their impact by resorting to an excessive use of tables of vital statistics, a practice which had greatly limited the usefulness of the later MOH reports. Insufficient attention was given generally to groups such as the disabled and mentally ill or to the interface between primary and secondary health care. Lack of reliable local data was usually responsible for these omissions.

RECOMMENDATIONS

Experience gained by the production of public health reports in the UK can be applied usefully to the Australian health-care setting:

- Directors of public health in Australia should produce a regular report which describes the health of the population of their area or region.
- To encourage the use of data from a wide variety of sources in such reports, the Health Department should assist in the publication of a public health common data set which display a variety of indicators derived from demographic, morbidity and mortality data. These data would allow comparisons between areas, regions, States and the nation as a whole. Any inferences should be supported by appropriate statistical analysis.
- The DsPH report should be used to help assess the health needs of the population and should contain recommendations of use in the area or regional planning process.
- The report should be accessible to a wide readership.

Donald Holt
Director, Public Health Unit
Northern Sydney Area Health Service

1. DHSS. Public Health in England: The report of the Committee of Inquiry into the future development of the Public Health Function. HMSO London 1988 (Cm 289).
2. Department of Health. Annual health reports of Directors of Public Health. Department of Health London 1990, PL/CMO (90)12.
3. Farrow S, Wood N, Beattie A. A content review of the annual reports on the health of the population. Health Care Evaluation Unit, Department of Epidemiology and Public Health Medicine, University of Bristol, Bristol 1990.
4. West Lambeth Health Authority. Towards informed action for health. Directorate of Public Health, West Lambeth Health Authority, London 1989.
5. Department of Health. Annual reports on the health of the population. Public Health Common Data Set, Department of Health, London 1989.
6. Middleton J, Binysh K, Chisty V, Pollock G. How to write the annual report of the director of public health. *Brit Med J* 1991, 302: 521-524.

OPPORTUNITIES IN THE UNITED STATES

The US Epidemic Intelligence Service (EIS) annual conference and trainee assignment process could provide important models for the NSW Public Health Training Scheme.

The April conference, at the Centers for Disease Control (CDC) in Atlanta, Georgia, attracted a wide range of US public health professionals, including epidemiologists from most States and from the CDC.

My mission at the conference was to find out about EIS and then select a two-year training position, which begins this month. I came away with the strong belief that a local scientific meeting with emphasis on epidemiological investigations conducted by Public Health Trainees, the Epidemiology Branch and Public Health Units would provide a focus for building public health infrastructure in NSW.

The Communicable Disease Center was set up in 1946 by the United States Government, initially to investigate the malaria risk to people in the southern US. Over the next few years, that organisation developed into the Centers for Disease Control, which has since gained worldwide distinction for its epidemiological approach to public health problems. The CDC is now six centres, including:

- Center for Prevention Services
- Center for Environmental Health and Injury Control
- National Institute for Occupational Health and Safety
- Center for Chronic Disease Prevention and Health Promotion
- Center for Infectious Diseases
- National Center for Health Statistics

CDC is perhaps best known in Australia for its weekly publication *MMWR*, which provides latest infectious diseases and mortality surveillance data to US health professionals. Through EIS, CDC offers both domestic and overseas health departments assistance in disease outbreak investigations. Each year CDC recruits about 75 health professionals to train in epidemiology, disease surveillance, investigation and prevention with EIS.

The EIS conference is an annual scientific meeting at which EIS trainees and alumni present reports of recent public health investigations. The papers at this year's conference were outstanding, with reports on investigations into areas including:

- epidemiology and public health policy
- infant and child health
- concerns of the elderly
- health promotion and disease prevention
- injury
- infectious diseases
- institutional health
- iatrogenic disease
- school-associated problems
- occupational health
- international health
- immunisation
- minority health
- surveillance

The quality of the papers was complemented by the high level of discussion that followed each presentation, probing epidemiological methodology and public health significance.

The conference also provided an opportunity for the 76 EIS recruits to meet epidemiologists offering training positions within the CDC or State health departments.

The formal EIS selection process was held the weekend after the conference. Each day recruits had around 20 15-minute timeslots in which to interview up to 150 epidemiologists offering training positions. After the interviews, recruits and supervisors ranked each other and, with the aid of a computer, the CDC assigned recruits to positions (mine is with the Oregon State Health Department).

My major impressions of CDC were the warmth of the staff and their commitment to public health and epidemiology.

Jeremy McAultry
Public Health Officer

CATCHING A MEASLES OUTBREAK

A measles outbreak in the Central Sydney Health Area between February and April this year produced some interesting information about immunisation levels.

Two cases were reported to the Medical Officer of Health for Central and Southern Sydney by general practitioners on March 8. One was a six-year-old boy who attended an inner-city primary school. The other was a 12-year-old boy from an inner-city high school. The outbreak spread rapidly and, by March 26, 38 confirmed or suspected cases of measles had been identified.

In the first three weeks of March control measures included motivation of parents of cases and contacts to ensure that all unimmunised children were immunised. Immunisation sessions were held in all five schools where cases had been identified.

The proportion of pupils in each school who were immunised with measles/mumps/rubella vaccine varied from 4 per cent to 50 per cent. Initial poor response rates were probably due to an attempt to immunise only those children who had not been immunised previously. However, measles immunisation status was unknown for many children, so immunisation was offered to all children. Uptake rates improved after that decision was made.

During the third week of March, it became evident that there was a significant outbreak among Aboriginal children in the suburb of Redfern. An immunisation day was held in the local early childhood centre and the Aboriginal community was encouraged through door-knocks to take their children for immunisation. During the door-knocks information was also sought on further cases of measles. On the immunisation day only seven children attended for measles immunisation.

On March 27, a case of measles was reported in a 16-year-old girl who attended an inner-city high school. No cases of measles had previously been identified in this school. Her 19-year-old cousin, who worked in a boarding school, had also contracted measles. It was not possible to undertake school-based immunisation before the Easter break and the school holidays. In an effort to control further spread of the outbreak the NSW Health Department issued a press release on March 28 which confirmed the presence of a measles outbreak and encouraged parents to ensure their children were immunised.

Over the Easter period several cases of measles were noted in a single street in the suburb of Glebe. With the cooperation of local general practitioners an immunisation stall was held in the street on Easter Sunday and Monday. Over the two days 95 children were immunised with measles/mumps/rubella vaccine.

After the holidays, all schools and day centres in the Central Sydney Area were contacted and asked to distribute a copy of a standard "dear parent" letter to each child. The letter described the measles outbreak, the possible complications of measles and encouraged all parents to ensure their children were immunised against measles. Schools and day care centres were asked to report all cases of measles to the Public Health

Unit. At the same time the local government councils of Sydney and South Sydney organised a letter drop to more than 30,000 homes in the inner-city, encouraging parents to immunise their children and providing information on council immunisation services.

The outbreak lasted about seven weeks. More than 80 per cent of cases occurred in the inner-city area. The index case was the 12-year-old whose measles was initially reported on March 8. The source of his infection is unknown.

Measles was confirmed in 46 children between 11 months and 19 years of age. A further nine cases of probable measles were identified. Several suspected cases were unable to be traced. Serological confirmation was obtained in six cases, including the index case. Of the confirmed cases, 23 were female and 23 male. No confirmed cases were admitted to hospital with a complication of measles.

Figure 1 shows the number of cases by age. Of the 46 confirmed cases 10 (22 per cent) occurred in the pre-school age group (less than five years of age), 4 (9 per cent) occurred in children less than 15 months of age, and 2 (4 per cent) occurred in children less than 12 months of age.

Transmission occurred in a variety of ways — in schools, contact with neighbours and within families. There was no evidence of transmission occurring in day care centres; pre-school age children developed measles through contact with neighbours or family members.

Figure 2 shows the number of cases by date of onset of illness. The Medical Officer of Health was notified of the first case on March 8 — at the peak of the outbreak. Over the next three weeks control strategies included school-based immunisation programs and motivation of the families of cases and contacts. By March 28, when the NSW Health Department issued the press release, the incidence of measles was decreasing. Within one week of the Easter period, and the extensive media coverage at that time, the outbreak had ended.

Of the confirmed cases, 3 (7 per cent) had documented evidence of prior measles immunisation and 31 (67 per cent) had no history of measles immunisation. A history of measles immunisation was unable to be confirmed in 12 (26 per cent) cases. Measles immunisation histories which were obtained from parents of children in the "unconfirmed" group were, for the most part, very doubtful. It is likely that most, if not all, of these children were not immunised against measles.

If the efficacy of measles vaccine and the percentage of measles cases with a proven history of measles immunisation is known, then the percentage of the population which has been vaccinated against measles may be calculated (Anonymous, 1980). In the case of this outbreak only 7 per cent of cases had a confirmed history of measles immunisation. Assuming a vaccine efficacy of 95 per cent, the coverage rate for measles vaccination may be as low as 60 per cent in the affected areas. The spread of the outbreak among children who are mostly

Continued on page 69 ▶

FIGURE 1

NUMBER OF MEASLES CASES BY AGE

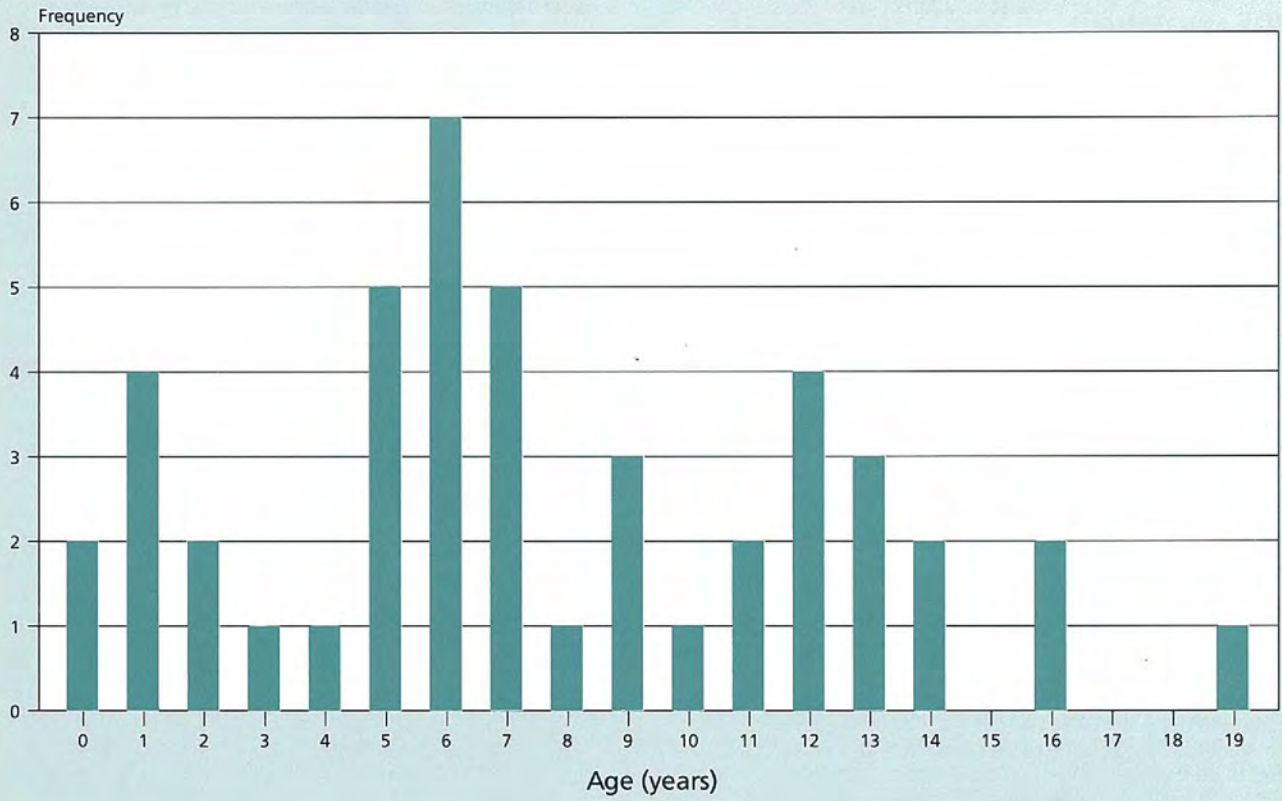
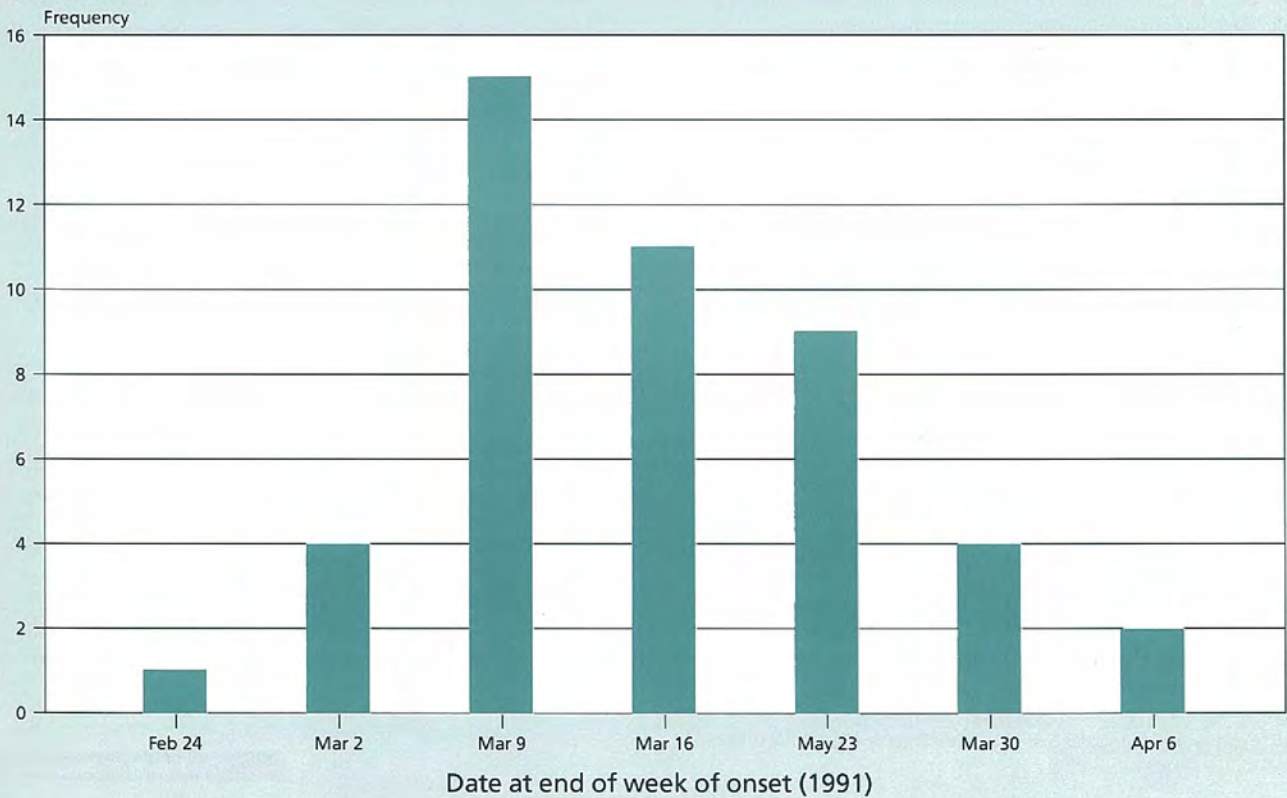


FIGURE 2

NUMBER OF MEASLES CASES BY WEEK OF ONSET



PUBLIC HEALTH ABSTRACTS

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

AIDS AND LESBIANS

Very little has been written on the epidemiology of AIDS in the lesbian population. Two instances of female-to-female sexual transmission of HIV have been reported. The biggest risk of transmission is, however, through intravenous drug use. Although female-to-female transmission of HIV appears to be rare, the occurrence of AIDS among lesbian and bisexual women indicates that women who engage in sex with other women can be exposed to HIV through the transmission of body fluids.

Chu SY, Buehler JW, Fleming PL and Berkelman RL, Epidemiology of Reported Cases of AIDS in Lesbians, United States 1980-89, *Am J Pub Health* 1990, 80: 1380-1381.

CHANGE OF FOOD IN US BOARDING SCHOOLS

The traditional counselling approach to changing eating behaviour is difficult and time-consuming. An alternative approach is to change the fat content of food products. Studies at two boarding high schools in New England have shown this can be achieved with an increase of consumption by 75 per cent of fat-modified products. (The key is to alter food purchasing and preparation practices in institutions rather than to try to change eating behaviour — JSL.)

Ellison RC, Goldberg RJ, Witschi JC et al, Use of Fat-Modified Food Products to Change Dietary Fat Intake of Young People, *Am J Pub Health* 1990, 80: 1374-1376.

CHLAMYDIA AND GONORRHOEA

The epidemiology of chlamydia is not well known because reliable and inexpensive tests have become available only recently. American studies show that chlamydia, a major cause of sexually-transmitted disease leading to sterility, appears to infect younger people and those of higher socio-economic status than gonorrhoea. Gonorrhoea is generally reported to central authorities, but that is not necessarily the case with chlamydia. It is recommended that chlamydia reporting to health departments be compulsory.

Zimmerman HL, Potterat JJ, Dukes RL et al, Epidemiologic Differences between Chlamydia and Gonorrhoea, *Am J Pub Health* 1990, 80: 1388-1342.

ATHEROMA AND COFFEE DRINKING

Whether coffee drinking is a risk factor for coronary heart disease continues to be controversial. A new American study has found that coffee-drinking behaviour is often associated with people who also consume higher fat diets. Hence the difficulty in interpreting the growing body of literature about coffee and health.

Puccio EM, McPhillips JB, Barrett-Connor E and Ganiats TG, Clustering of Atherogenic Behaviours in Coffee Drinkers, *Am J Pub Health* 1990, 80: 1310-1313.

GROUP THERAPY APPEARS TO HELP

The risk of sex offenders re-offending is known to persist over many years. A 10-year experience in England has shown that group therapy can achieve reasonable results with non-violent sex offenders. The key activities in the group therapy are acknowledgement of the problem, discussion of the build-up to sex offences, development of alternative strategies when at risk of re-offending, implementation of these strategies and development of supports outside the group.

Cook DAG, Fox CA, Weaver CM and Rooth FG, The Berkeley Group: Ten Years' Experience of a Group for Non-violent Sex Offenders, *Brit J Psych* 1991, 158, 238-243.

DAY TREATMENT SUCCEEDS

A new British-based study has shown that up to 50 per cent of acutely psychiatrically ill patients can be adequately cared for on a day hospital basis without the need for admission. Adequate numbers of staff are necessary if the proportion of such patients is to reach 50 per cent of all patients referred for hospital admission. The number of staff required for satisfactory day hospital treatment of acutely ill patients means day care may not necessarily be cheaper than inpatient care.

Creed F, Black D, Anthony P, Osborn M et al, Randomised Controlled Trial of Day and In-patient Psychiatric Treatment, *Brit J Psych* 1991, 158, 183-189.

VASECTOMY AND PROSTATE CANCER

Vasectomy is widely regarded as a safe, simple and effective form of male contraception. But a large, carefully controlled American study has raised the possibility that vasectomy may increase the long-term risk of cancer of the prostate. This is not a conclusive finding and other studies do not confirm it. As prostate cancer is now the leading site for cancer incidence in men and should increase as the age distribution of the population shifts upward, this issue will become more important.

Guess HA, Vasectomy and Prostate Cancer, *Am J Epidem* 1990, 132, 6, 1062-1065.

ADVERSE EVENTS IN HOSPITAL PATIENTS

A large American study has shown that 3.7 per cent of hospital patients have disabling injuries caused by medical treatment. Nearly half the adverse events resulted from operations, with wound infection being the most common. Drug complications were the most common single type of adverse event. Overall, 28 per cent of the adverse events were judged to have been as a consequence of negligent care, by far the most common being omission of action. It is also important to indicate that the large majority of the adverse events did not result in serious disability.

Many of the adverse events were neither preventable nor predictable, given the state of knowledge — for example, idiosyncratic drug reactions in patients who had not taken drugs previously. The findings indicate that most adverse events are preventable and that errors in medical practice are relatively common. However studies in other areas of human endeavour such as nuclear power generation, shipping and the airline industry confirm that some degree of error is inherent in all human activity. In highly technical systems, even minor errors may have disastrous consequences and medicine is no exception. To reduce error, control will require scientific advances in some instances, but progress will also depend heavily on education and the development and dissemination of guidelines and standards for practice. Preventing medical injury will also require attention to the causes and consequences of errors, an effort that goes well beyond identifying culpable people. Such approaches have paid off handsomely in other highly technical and complicated enterprises such as aviation, and similar strategies may work in medicine as well.

Leape LL, Brennan TA, Laid N et al, The Nature of Adverse Events in Hospitalised Patients, *New Eng J Med* 1991, 324: 377-384.

Continued on page 68 ▶

► Continued from page 67

PREDICTORS OF SUCCESSFUL AGEING

The elderly are not a homogeneous group. Some are beset by multiple conditions and spend considerable time in hospital. Others, especially women, live a very long life but are afflicted by increasing frailty or declining mental status. Some elderly manage to avoid all these problems and maintain themselves independently in the community and are described as "ageing successfully".

A large Canadian study conducted over nearly 15 years has identified predictors of successful ageing. These are no bad outcomes occurring to a spouse, good self-reported health status, not developing cancer or diabetes, and having good mental health status.

Females were no more likely to age successfully than were males. In summary, successful ageing depends on good health status (including mental health) and not having one's spouse die or enter a nursing home.

Roos NP and Havens B, Predictors of Successful Ageing: a 12-year study of Manitoba elderly, *Am J Pub Health* 1991, 81: 63-68.

NORTH COAST CHOLESTEROL CHECK CAMPAIGN

More than half the North Coast adult population has now had a cholesterol test. About half have elevated blood cholesterol levels. Follow-up has indicated that after three years, between 6 and 10 per cent reduction in blood cholesterol has been achieved. As each per cent reduction in blood cholesterol gives 2 to 3 per cent reduction in heart disease, this campaign can be regarded as being effective. (The desirability of conducting large-scale public screening programs continues to be a matter of debate. During the 1970s similar results of public screening programs in northern Sydney were achieved, but were not followed up because better results were being achieved through widespread health education — JSL.)

van Beurden EK, James R, Henrikson D et al, The North Coast Cholesterol Check Campaign, *Med J Aust* 1991, 155, 385-391.

TRENDS IN ABORIGINAL MORTALITY

The level of mortality experienced by Aborigines has long been recognised as much worse than that of other Australians. Although the overall situation has probably improved slightly over the past 20 years, the current level is still much higher than that of non-Aboriginals and there is some evidence that the death rates of young and middle-aged adults may have risen in that time. The number of Aboriginal deaths in virtually all Aboriginal communities is about double that of other Australians. Accordingly, the life expectation is from 10 to 15 years less for both male and female Aborigines.

The causes of Aboriginal deaths have changed in recent years. In 1985 the leading cause of death for Aboriginal males and females was disease of the circulatory system. The second leading cause of death for males and the third for females was injury and poisoning. Diseases of the respiratory system is the third leading cause of death. Cancers are of increasing importance as causes of Aboriginal deaths.

Infectious and parasitic diseases are still a much higher cause of death in the Aboriginal community than for other Australians and include tuberculosis, intestinal infectious diseases plus a range of other infections. Infant mortality rates appear to have declined substantially among

Aborigines in the past 20 years, but the infant mortality rates remain between two and four times higher than that of other Australians.

Thomson NJ, Recent Trends in Aboriginal Mortality, *Med J Aust* 1991, 154, 235-239.

CAN RADIOGRAPHERS REVIEW EMERGENCY X-RAYS?

A British study has shown that radiographers can offer useful advice on radiographs to casualty officers, but they have a high rate of false positive diagnoses. Nevertheless their error rate of 9 to 14 per cent is considerably lower than the 39 per cent reportedly made by casualty medical officers. It is concluded that radiographers can offer useful advice, but that all X-ray films should be ultimately reviewed by a specialist radiologist.

Renwick IGH, Butt WP and Steele B, How Well Can Radiographers Triage X-ray Films in Accident and Emergency Departments? *Brit Med J* 1991, 302, 568-569.

BREAST CANCER IN YOUNG WOMEN

Mortality from breast cancer has not changed over the past 30 years. Accurate early diagnosis is needed to improve quality of life and reduce mortality as the outcome depends on tumour size at presentation. About two-thirds of patients at British breast clinics are younger than 36 years. While most have benign disease, roughly 3 per cent of all cancers occur in this age group. This study assessed the diagnostic processes — clinical examination, mammography and needle aspiration biopsy — in young women with breast cancer. The conclusions are that mammography alone seems inadequately sensitive to detect breast cancer in young patients. When all investigations give negative results, excision biopsy appears to be the only way of obtaining a definitive diagnosis.

Yelland A, Graham MD, Trott PA, Diagnosing Breast Carcinoma in Young Women, *Brit Med J* 1991, 302, 618-620.

ACTING ON HIGH CHOLESTEROL LEVELS

Screening hand luggage for explosive devices is widely accepted at airports. In contrast, screening for high blood cholesterol levels which, in some people, is the same as carrying around a biological time bomb, is contentious. A Canadian committee has exhaustively reviewed the issue. They did not recommend mass screening but strongly advocated a population-based strategy of dietary change with screening limited to those at high risk who present to doctors for other reasons. Another recent review of screening, this time from the United States, assessed the same evidence and reached similar conclusions but with one major difference. They advocated that all men have their serum cholesterol concentration measured at least once in early adult life.

The reason for these approaches is that mass screening would lead to a massive expansion of laboratory and dietary facilities plus the need to give expensive blood fat lowering medication to perhaps one in four adults. The outcome would not necessarily be better than the population-based strategy of dietary change. (See earlier item on the approach adopted in the NSW North Coast.)

Thompson GR, What Should be Done About Asymptomatic Hypercholesterolaemia? *Brit Med J* 1991, 302, 605-606.

Continued on page 69 ►

Public Health Abstracts

► Continued from page 68

UNEMPLOYMENT — HERE WE GO AGAIN

Galbraith, the world's most literate economist, has said: "Let us remind ourselves what lies behind those numbers (on unemployment) — personal and family trauma, the loss of self-esteem, the tight-lipped fear about the future, the wonder as to whether there will be a job and income soon or ever again." These issues are crucial to health because all the radical solutions lie with economists and politicians, yet the evidence is that unemployment kills — particularly the middle-aged. There have been many studies in the past two decades which document that mortality is roughly a third higher in men seeking work than employed men. In 1990 a Finnish study found that mortality was 90 per cent higher among the unemployed than the employed after controlling for all the background variables. This Finnish study also showed that mortality increased with duration of unemployment. In all the studies, death rates are particularly high from suicide, accidents and violence and circulatory diseases.

Smith R, Unemployment: here we go again. *Brit Med J* 1991, 302, 606-607.

FLUORIDATION — AN OLD CONTROVERSY

Few public health activities engender more heat than the recurrent debate over fluoridation. In response to attacks led by scientists, the National Health and Medical Research Council's new working group to review the issues has issued an interim report. The basic conclusions are that fluoridation of water supplies does provide a good base for the reduction in dental decay in any community. The working group acknowledges that fluoridated toothpastes have also provided a major source of fluoride. Its basic recommendation is to encourage communities with reticulated water supplies, which are not fluoridated, to go ahead and fluoridate them.

If fluoride were removed from water supplies, the outcome would not be disastrous because of the high levels of fluoride and the widespread levels of fluoride-containing toothpastes and the increasing level of oral hygiene with these toothpastes.

Douglas RM, Fluoridation of Public Water Supplies. *Med J Aust* 1991, 154, 435-436.

PREGNANCY AND THE OUTCOME OF MELANOMA

The incidence of melanoma is rising and it appears to be developing in twice as many women as men. Thus a large proportion of women who have had melanoma apparently successfully excised are still in their reproductive period. In view of the possibility of tumour sensitivity to hormones, women increasingly ask whether pregnancy after treatment alters the outlook, particularly with respect to melanomas diagnosed during a previous pregnancy. A large British study has shown that once the thickness of the melanoma tumour is controlled, the survival rate of pregnant women in whom melanoma was diagnosed and treated did not differ from that of other women. Therefore women with melanoma should be advised about pregnancy on the basis of thickness and site of tumour and evidence of vascular spread and not on hormonal status (this is a major change in practice in a very important and common field for Australia — JSL).

MaeKie RM, Bufalino R, Morabito A. Lack of Effect of Pregnancy on Outcome of Melanoma. *Lancet* 1991, 337, 653-654.

Catching a Measles Outbreak

► Continued from page 65

unimmunised and who are resident in the inner-city area indicates a need to review childhood immunisation strategies in this area.

Delayed reporting of measles cases resulted in control measures not being instituted until the outbreak was well under way. The investigation of the outbreak showed that, of the two cases reported on March 8, one was a secondary contact of the index case. The index case was not reported until serological confirmation had been obtained — two weeks after the onset of illness. It is likely that many cases of measles could have been prevented if the doctor had notified the case on suspicion of measles rather than waiting for serological confirmation.

The control of a measles outbreak rests on the rapid immunisation of susceptible children. In this outbreak, measles immunisation was recommended for all unimmunised children over one year of age. Measles immunisation is not usually recommended for children less than six months of age because maternal antibody levels are usually sufficient to prevent infection. Measles immunisation may be given to children aged 6 to 12 months — but a second dose is recommended at 15 months of age. Alternatively, human immunoglobulin may be given to provide temporary protection. In this outbreak, the lack of any clear guidelines for protection of children aged 6 to 12 months caused some confusion among health care workers and the public. It is therefore important, in the event of a measles outbreak, that health care workers be provided with clear guidelines for this age group.

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Anonymous. Measles vaccine efficacy — United States. *MMWR*, 1980; 29: 470-472.

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Suggestions for improving the content of the Bulletin are welcome.

INFECTIOUS DISEASES

NOTIFICATIONS

Implementation of the new infectious disease notification and control system is progressing well. Regulations for the Public Health Act (1991) are being prepared and new forms are being designed for doctors and laboratories. They will be a pre-addressed, reply-paid and tick-box type aerogram format.

Our aim is to make the forms functional and attractive and we plan to have the new system ready by October 1991.

A special edition of the *Public Health Bulletin* will inform health care workers how they can make the system work. Distribution of the new forms and promotion of the new system are planned for September.

The infectious diseases data received by Epidemiology Branch up to July 1 fail to reflect the infectious diseases situation in NSW. Substantial delays in notification are still encountered. As an example, those cases reported for the month of May in the June *Public Health Bulletin* represented only 24 per cent of total notifications for that period.

Only 265 notifications have been received through the Infectious Diseases Database System (IDDS) for June. It is notable that only one case of Hepatitis A has been entered on to IDDS. The other cases were elicited by active surveillance through Public Health Units.

To address concerns about IDDS a series of one-day tutorials involving Epidemiology Branch and Public Health Unit staff has been arranged. The tutorials will cover IDDS (version 1.7), a review of all records held by each Public Health Unit and the distribution of version 1.7 (disc and accompanying manual).

Reports of Hepatitis A notifications have risen significantly this year. For 1990, 36 cases were reported in the Public Health Bulletin compared to more than 214 cases of Hepatitis A reported to the Health Department for the period January to June 1991. Hepatitis A rates range from 53.8/100,000 population/year in the Eastern Sydney Area, 11.6/100,000 in the Northern Sydney Area, 10.2/100,000 in the Central and Southern Sydney Area to less than 6/100,000 population/year in the Regions. Males account for more than 72 per cent of all notifications.

In response to the notifications, staff of the Eastern Sydney Public Health Unit have contacted all general practitioners in the area informing them of the outbreak and offering assistance with management protocols. A media release was prepared by the staff of Health Public Affairs, Epidemiology Branch and the Eastern Sydney Public Health Unit.

Eleven PHUs have notified measles this year. Eight cases have been notified from the Eastern Sydney Public Health Unit for a rate of 29.7/100,000 population per year.

Leptospirosis has attracted increased attention recently through the Department of Agriculture's awareness campaign, South West Region notified leptospirosis at a rate of 3.98/100,000 population/year. Public Health Units that recognised that this condition is of regional importance have been encouraged to collaborate with Department of Agriculture officers. Immunisation of livestock is recommended.

TABLE 1

INFECTIOUS DISEASES
NOTIFICATIONS, NSW
To the end of June 1991

CONDITION	Number of Cases Notified			
	Period		Cumulative	
	June 1990	June 1991	June 1990	June 1991
AIDS	17	N/A	*143	*77
Arboviral infections (NOS)	-	3	1	300
Brucellosis	2	1	5	3
Cholera	-	-	-	-
Diphtheria	-	-	-	-
Foodborne illness (NOS)	1	148	11	1629
Gastroenteritis (instit.)	N/A	-	N/A	24
Gonorrhoea	37	10	243	180
H influenzae infection (NOS)	2	4	10	59
H influenzae B — meningitis	2	-	10	-
H influenzae B — septicaemia	1	-	2	1
Hepatitis (NOS)	-	70	2	655
Hepatitis A	3	27	17	63
Hepatitis B — acute	4	-	6	2
Hepatitis B — carrier	-	-	-	7
Hepatitis B — unspecified	30	1	235	126
Hepatitis C	1	-	17	32
HIV infection	N/A	N/A	*273	*299
Hydatid disease	-	-	2	-
Legionnaires' disease	1	-	18	15
Leprosy	-	-	-	-
Leptospirosis	3	-	26	22
Listeriosis	N/A	-	N/A	-
Malaria	13	4	95	20
Measles	11	8	51	93
Meningococcal infection (NOS)	1	-	16	15
Meningococcal meningitis	6	-	17	6
Meningococcal septicaemia	2	-	5	5
Mumps	N/A	1	N/A	5
Mycobacterial infection (NOS)	-	5	-	75
Mycobacterial tuberculosis	48	1	252	7
Mycobacterial — atypical	5	-	14	8
Pertussis	4	-	103	28
Plague	-	-	-	-
Poliomyelitis	-	-	-	-
Q fever	10	-	77	90
Ross River fever	23	-	219	114
Rubella	N/A	3	N/A	18
Salmonella infection (NOS)	99	2	821	512
Syphilis	28	1	171	179
Tetanus	-	-	-	2
Typhoid & paratyphoid	3	-	6	15
Typhus	-	-	-	-
Viral haemorrhagic fever	-	-	-	-
Yellow fever	-	-	-	-

* Data January-April only

Continued on page 71 ►

TABLE 2

**INFECTIOUS DISEASE NOTIFICATIONS
BY HEALTH AREA & REGION
FOR PERIOD JANUARY 1 TO JUNE 30, 1991**

CONDITION	CSA	SSA	ESA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NCR	NER	OFR	CWR	SWR	SER	OTH	U/K	TOTAL
AIDS*	9	2	33	3	7	3	10	4	-	1	3	-	-	-	-	-	-	2	77
Arboviral infection (NOS)	-	-	13	-	-	-	-	-	-	6	-	134	105	4	36	2	-	-	300
Brucellosis	-	-	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3
Cholera	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1
Foodborne illness (NOS)	28	34	845	40	85	81	43	6	13	53	185	72	44	23	65	2	10	-	1629
Gastroenteritis (instit.)	-	-	-	4	9	6	-	-	-	-	-	5	-	-	-	-	-	-	24
Gonorrhoea	-	3	116	18	5	-	1	-	4	3	6	1	18	-	5	-	-	-	180
H Influenzae infection (NOS)	-	-	15	-	8	7	-	-	4	4	-	-	1	-	7	2	-	-	48
Haemophilus influenzae B	-	-	-	-	3	1	2	-	2	-	-	1	-	-	2	-	-	-	11
Haemophilus septicaemia	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Hepatitis (NOS)	3	-	388	28	124	6	-	-	8	20	-	22	34	-	8	14	-	-	655
Hepatitis A	11	5	-	1	4	-	7	1	-	4	3	1	-	-	-	-	-	26	63
Hepatitis B - acute	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	-	2
Hepatitis B - carrier	4	1	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	7
Hepatitis B - unspecified	40	8	3	7	6	3	13	-	2	9	17	6	11	-	-	-	1	-	126
Hepatitis C	15	1	-	1	3	-	-	-	-	-	8	4	-	-	-	-	-	-	32
HIV infection	21	6	71	8	17	2	18	1	2	10	8	-	1	1	-	1	2	130	299
Legionnaires' disease	-	-	-	4	4	2	1	-	-	2	-	-	-	-	1	-	1	-	15
Leptospirosis	-	-	-	-	-	-	1	-	-	8	1	2	2	-	5	-	3	-	22
Malaria	-	-	4	-	3	1	3	-	1	1	1	-	-	-	4	2	-	-	20
Measles	1	-	10	6	16	1	5	-	3	27	13	2	1	-	1	7	-	-	93
Meningococcal infection (NOS)	-	-	1	2	1	1	-	-	4	1	1	4	1	-	-	-	-	-	15
Meningococcal meningitis	-	1	-	-	-	-	1	-	-	2	1	-	-	-	-	1	-	-	6
Meningococcal septicaemia	-	-	-	-	-	-	-	-	-	-	4	-	-	-	-	1	-	-	5
Mumps	-	-	3	-	1	-	-	-	-	-	-	-	-	-	1	-	-	-	5
Mycobacterial atypical	2	3	-	-	1	-	2	-	-	-	-	-	-	-	-	-	-	-	8
Mycobacterial infection (NOS)	-	-	18	7	20	6	1	-	9	1	3	2	1	3	-	-	-	-	71
Mycobacterial tuberculosis	1	5	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	7
Mycobacterial - other	-	-	-	-	-	-	-	-	1	-	-	-	1	-	2	-	-	-	4
Pertussis	-	-	10	3	2	1	1	-	-	1	3	-	5	-	2	-	-	-	28
Q Fever	-	-	-	1	-	-	-	-	-	3	7	17	55	3	3	1	-	-	90
Ross River fever	-	-	-	-	-	-	-	2	-	1	11	71	21	-	4	-	5	-	114
Rubella	-	-	15	-	-	1	-	-	1	1	-	-	-	-	-	-	-	-	18
Salmonella infection (NOS)	38	38	7	55	86	45	32	5	35	14	41	38	37	10	10	8	13	-	512
Syphilis	10	4	12	23	15	3	1	1	3	13	30	12	44	3	3	1	1	-	179
Tetanus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	-	2
Typhoid & paratyphoid	2	-	4	-	-	-	3	-	1	2	-	2	-	-	-	-	1	-	15

* Data January-April only

1572

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TABLE 3

**INFECTIOUS DISEASE NOTIFICATIONS
BY HEALTH AREA & REGION
FOR MONTH OF JUNE, 1991**

CONDITION	CSA	SSA	ESA	SWR	U/K	TOTAL
Arboviral infection (NOS)	-	-	2	1	-	3
Brucellosis	-	-	1	-	-	1
Foodborne illness (NOS)	1	1	140	6	-	148
Gonorrhoea	-	-	10	-	-	10
H Influenzae infection	-	-	4	-	-	4
Hepatitis (NOS)	-	-	69	1	-	70
Hepatitis A	1	-	-	-	-	1
Hepatitis B - unspecified	1	-	-	-	26	27
Malaria	-	-	4	-	-	4
Measles	-	-	8	-	-	8
Mumps	-	-	2	1	-	3
Mycobacterial infection (NOS)	-	-	5	-	-	5
Mycobacterial tuberculosis	-	1	-	-	-	1
Rubella	-	-	3	-	-	3
Salmonella infection (NOS)	2	-	-	-	-	2
Syphilis	-	-	1	-	-	1
Total	5	2	249	9	26	291

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

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.