



INJURY PREVENTION STRATEGY MAKING GOOD PROGRESS

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SUMMARY

This article reports on the first review of the NSW Injury Prevention Strategy which was released in July 1992¹. The review aimed to identify strengths and weaknesses in the strategy's content and its implementation, and to recommend changes to ensure the strategy is targeted correctly, maintaining relevance to injury prevention issues. The review demonstrated that the strategy is progressing well, with a large number of the 1992-93 implementation indicators achieved and many of the indicators for 1994 and 1995 being addressed. The results and recommendations from the review were presented to NSW injury prevention workers at the Injury Prevention Planning Day in June 1994. The recommendations were discussed and an agreement on future directions was reached.

BACKGROUND AND METHODS

Injury is the major cause of premature death and disability in NSW². The importance of preventing injury was recognised by the NSW Health Department in 1992 when the Injury Prevention Strategy entitled Preventing Injury was released after extensive consultation. The strategy built on established processes and focused resources by presenting priorities for injury prevention initiatives over the next decade. Seventeen goals and targets were identified and these are summarised in Table 1. Intervention strategies with corresponding implementation indicators were proposed for each goal and target.

To determine which parts of the strategy had been implemented in 1992 and 1993 we conducted a review in which we:

- interviewed health workers in the Areas, Regions and head office of the NSW Health Department involved in injury prevention;
- contacted organisations such as the Roads and Traffic Authority and local councils; and
- extracted information from annual and final reports written by Health Promotion Units in the past two years.

FINDINGS

Twelve of the 17 injury prevention goals had work scheduled for 1992 and 1993. For one goal the work requirements were achieved, six were substantially achieved, three were partially achieved and for two goals they were not achieved (Table 2). Progress was made on several other goals, in particular falls in older people, which has already achieved several program objectives set down for 1995.

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TABLE 1

SUMMARY OF THE 17 INJURY GOALS IDENTIFIED IN THE NSW INJURY PREVENTION STRATEGY

Injury Category	Goal
All injury	1. To reduce disability and death due to injury
Children's injuries	2. To reduce death due to drowning
	3. To reduce disability and death due to bicycle injuries
	4. To reduce disability due to unintentional poisoning
	5. To reduce disability and death due to falls
	6. To reduce disability due to burns and scalds
Older people's injuries	7. To reduce disability and death due to falls in older people
Rural injuries	8. To reduce disability and death due to injury and death in rural areas
Transport injuries	9. To reduce disability and death due to road crashes
	10. To reduce the number of road crashes attributable to alcohol
Occupational injuries	11. To reduce disability and death due to workplace injuries
Sports injuries	12. To reduce disability due to sports injuries
Iatrogenic injuries	13. To reduce disability and death due to iatrogenic (medically-induced) injuries
Intentional injuries	14. To reduce disability and death due to suicide and attempted suicide
	15. To reduce disability and death due to domestic violence
	16. To reduce the incidence of child abuse and neglect
	17. To reduce disability and death due to other forms of intentional injury

Source: NSW Health Department Injury Prevention Working Group. Preventing Injury in NSW (1992).

Injury prevention strategy

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Several other important advances have been made, including:

- developing surveillance systems to monitor most of the injury problems;
- forming specific injury prevention networks to provide support and distribute information to practitioners on effective prevention strategies. Networks have been set up for older people's falls, children's injuries, playground safety and farm safety;
- providing training opportunities for injury prevention workers;
- involving the community in injury prevention; and
- collaborating with other agencies to reduce injury.

We assessed trends in injury rates for all 17 priorities from 1970 (where data were available) to the time the injury

TABLE 2

PROGRESS OF THE NSW INJURY PREVENTION STRATEGY - 1992-93 WORK PROGRAM

Performance	Activities to support strategy	Prevention programs
Achieved	- Development of infrastructure	- Burns and scalds
Substantially achieved	- Establish surveillance systems - Strategies to reduce death and disability due to injury - Links with other organisations	- All injury - Drowning - Bicycle-related injury - Falls in children - Rural injuries - Domestic violence
Partially achieved	- Develop community ownership and involvement in injury prevention	- Suicide - Child abuse - Other forms of intentional injury
Not achieved		- Blood alcohol concentration-related transport injuries - Occupational injuries

strategy was formally endorsed in 1992-93 to set a baseline for future evaluation of the strategy. We found decreasing rates had been established for five areas, whereas injury rates were stable for another five areas and increasing in two. It was not possible to tell what was happening for the remaining five areas because there were inadequate data (Table 3).

FUTURE DIRECTIONS

Since 1992 NSW Health has made good progress implementing its Injury Prevention Strategy and building a supportive environment to achieve real gains in injury control.

The strategy addresses a wide range of issues. This broad approach has advantages in that most relevant areas are highlighted, but it also means resources may not be deployed as efficiently as they might be to maximise the health outcomes. Major recommendations from the review include a greater concentration of our efforts on selected injury areas and adopting better evaluation mechanisms for monitoring.

We propose that a more managed approach to the development and implementation of strategies and to the allocation of resources for injury control be adopted as the strategy evolves for selected injury problems. This should include the review, development and implementation of integrated Statewide plans for the control of:

- children's playground injuries
- burns and scalds
- older people's falls
- domestic violence
- child abuse
- suicide

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IN-LINE SKATING INJURIES IN CHILDREN IN EASTERN SYDNEY

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Injury is an important cause of deaths and hospitalisations of Eastern Sydney children¹. More than one-third of hospital admissions for injury in 1989-90 were due to falls¹. We investigated one cause of an epidemic of falls in children in Eastern Sydney in the early 1990s: the in-line skating 'craze'. In-line skates or rollerblades were invented in the United States in the early 1980s² and consist of a boot attached to a single row of wheels, usually four. They became popular in Australia in the early 1990s.

In Eastern Sydney, the Prince of Wales Children's Hospital (POWCH) contributes to the national Injury Surveillance and Information System (ISIS) database. We consulted the hospital's ISIS database for information about presentations of children to the Emergency Department for in-line skating injuries. Our aim was to quantify and describe the injuries, identify factors for preventive action and recommend and implement measures locally to prevent or reduce injuries.

METHODS

Data were collected for all children (0 - <16 years) who were recorded by ISIS as presenting to the Emergency Department with in-line skating injuries between June 30, 1991 and June 30, 1993. Audits have shown that about 70 per cent of all injury presentations and 100 per cent of injury admissions are captured by ISIS at POWCH. Data were analysed using Epi-Info.

Information on in-line skate design and safety issues was sought from the literature, the Trade Practices Commission, the Australian Consumers' Association, the Australian Standards Association, the In-line Skaters' Association and retail and hire outlets. Information on the regulation of in-

line skating in Eastern Sydney was sought from the six local councils.

RESULTS

The first presentation to the POWCH for an in-line skating injury was in June 1991. Until June 30, 1993 there had been 139 presentations recorded, of which 73 per cent were male and 27 per cent female (Figure 1). A large increase in attendances in summer 1992-93 decreased to about two presentations weekly in autumn 1993 (Figure 2). Half the presentations were from boys aged 10-14 years (Figure 1). Most injuries (94 per cent) occurred when the child lost control and fell while moving. For 26 per cent of presentations, injury occurred while skating on the footpath and for 17 per cent injury occurred while skating on a public road (Figure 3). Of the children injured on public roads, one child was involved in a collision with a motor vehicle.

There were 153 injuries recorded for the 139 presentations. Twenty-eight per cent of children were admitted and 62 per cent of the children not admitted had injuries sufficiently serious to warrant outpatient follow-up. Sixty-five per cent of injured children sustained a fracture. Forearm fractures were most frequent: 38 per cent of all injuries were a fracture of the radius and/or ulna and 16 per cent of all injuries were wrist fractures. Four children had fractures of the tibia/fibula and four were concussed. There were no skull fractures or spinal injuries but one child had a fractured coccyx.

Data on safety equipment including helmets, wrist guards and knee and elbow pads were available for 128

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Injury prevention strategy

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To improve support for the strategy a greater emphasis needs to be placed on the development of outcome indicators and evaluation methods, and the individual needs of selected groups such as Aborigines and migrants.

The results from this evaluation will be published in a more detailed report available from the NSW Health Department from October 1994³. It is hoped that this document will form the basis of continuing consultation with injury prevention workers in NSW and revision of the strategy.

ACKNOWLEDGMENTS

David Lyle, Jane Elkington, Judy Jones, Shing Chung Fung and all NSW Health injury prevention personnel.

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2. Lewis P, Lyle D, Fung SC. Injury in New South Wales. Public Health Bulletin Supplement 1993 S-2.
3. Kim C, Lonie C. Preventing Injury: A Review of the NSW Injury Prevention Strategy. NSW Health Department (in press).

TABLE 3

TRENDS IN INJURY RATES AT THE TIME THE NSW INJURY PREVENTION STRATEGY WAS ADOPTED IN 1992-93

Trend	Injury outcome
Decreasing rates	- All injury - Motor vehicle accidents - Road deaths due to alcohol consumption - Bicycle-related deaths - Injuries in rural areas
Stabilised	- Children's falls - Burns and scalds - Adults' falls - Children's drowning - Suicides
Increasing rates	- Poisoning and ingestion - Occupational injuries
Difficult to tell	- Sports injuries - Child abuse - Iatrogenesis - Domestic violence - Other forms of intentional injury

In-line skating injuries

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presentations. Twenty-seven per cent of presenting children wore some form of protective clothing. Only 9 per cent were wearing a helmet at the time of injury. Fifty-six per cent of children wearing protective clothing of any sort and 65 per cent of those who wore no protective clothing sustained a fracture or concussion ($\chi^2=0.87$, $df=1$, $p=0.35$).

FIGURE 1

PRESENTATIONS OF CHILDREN FOR IN-LINE SKATING INJURIES TO POWCH ACCIDENT AND EMERGENCY DEPARTMENT JUNE 1991-JUNE 1993, BY AGE AND SEX

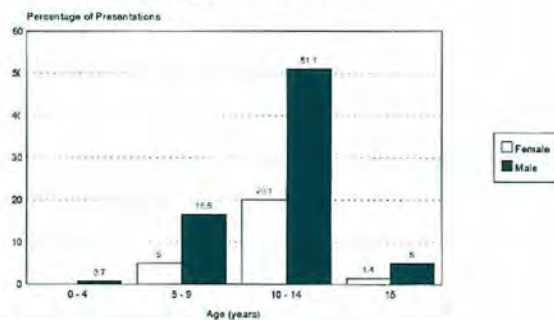


FIGURE 2

SEASONAL DISTRIBUTION OF CHILDREN'S PRESENTATIONS TO POWCH ACCIDENT AND EMERGENCY DEPARTMENT FOR IN-LINE SKATING INJURIES, WINTER 1991-AUTUMN 1993

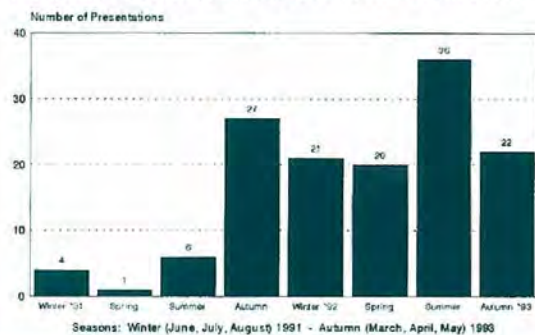
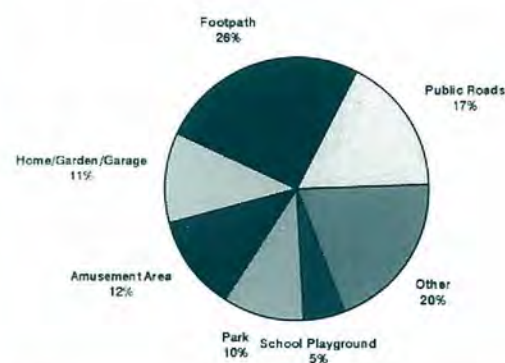


FIGURE 3

PLACE OF INJURY OF CHILDREN PRESENTING TO POWCH ACCIDENT AND EMERGENCY DEPARTMENT FOR IN-LINE SKATING INJURIES, JUNE 1991-JUNE 1993



DISCUSSION

The extent of the problem

The rapid popularity of new consumer products, such as skateboards or in-line skates, resulting in an epidemic of injuries has been previously documented^{3,4,5,6,7} and undermines advances in injury prevention and control. While there have been no child fatalities associated with in-line skating in NSW⁸, an epidemic of substantial injuries requiring hospital presentation has been recorded in Eastern Sydney since mid-1991. Other injury surveillance centres in NSW and Victoria report a similar epidemic and child injury profile^{9,10}. Children presenting to Emergency Departments because of in-line skating injuries probably represent the more severe end of the spectrum of injuries occurring in the underlying population of children engaging in the activity. Data about less severe injuries are not routinely available.

Safety issues

(i) Protective clothing

Protective clothing, including helmets, wrist guards and padding, is recommended by some manufacturers, the In-line Skaters' Association and others^{4,9,11}. Only 27 per cent of children presenting to POWCH with in-line skating injuries were wearing protective clothing at the time of their accidents. Protective clothing usage rates in the community may be higher, if children presenting with injuries are those less likely to be wearing it. Of the children presenting with injuries, wearing protective clothing was not associated with a reduced risk of fracture or concussion. Further study is needed to clarify the role of protective clothing. In the interim, it is not an expensive precaution – \$7-\$15 an item – in comparison with the cost of in-line skates – \$90-\$500 – and its regular usage should be encouraged. Spot checks in Eastern Sydney reveal that protective clothing is located beside in-line skates at points of sale and hire but encouragement of its purchase/usage is not routinely given.

(ii) Product safety

There is little information to indicate the role of the product in in-line skating injuries, e.g. are some brands more hazardous than others. Product brand details are not recorded in ISIS data. A large range of brands is imported into Australia but there is no Australian standard for in-line skates. A comprehensive mechanism for the evaluation of the safety of new consumer products is arguably needed in Australia. There is only a general safety provision under the Commonwealth Trade Practices Act whereby manufacturers or importers of 'defective goods' are liable to pay compensation if a defect causes injury, death or property damage¹². Under the act, 'defective goods' may include those inadequately labelled with safety instructions. Provision of safety information on in-line skate packaging varies from none to extensive advice on the use of protective clothing, the observation of traffic regulations, speed control and surfaces to avoid. Packaging should uniformly display this information and verbal advice should be given routinely at hire outlets.

(iii) The skating environment

Few areas are designated for skating in Eastern Sydney and increasingly walkways, shopping malls, cycleways and parks are bearing signs indicating prohibition of skating. Forty-two per cent of children presenting to POWCH with in-line skating injuries were injured on public roads or footpaths. Provision of more skating ramps, designated

IMPACT OF SYDNEY'S DEEPWATER OCEAN OUTFALLS ON GARIE BEACH

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In 1990 and 1991 three deepwater ocean sewage outfalls were commissioned (Malabar in September 1990, North Head in December 1990 and Bondi in August 1991) to alleviate the problem of frequent fouling of many of Sydney's premier ocean beaches¹. The main cause of the beach pollution was the discharge of inadequately treated sewage from nearby shoreline outlets.

The Sydney deepwater outfalls were sited a sufficient distance offshore so the waste field would be entrained in the predominant southerly, East Australia Current² and shoreline impacts would be minimised. But the implications of this alongshore transport in terms of ultimate contaminant fate are not fully understood^{1,2}.

A concern of environmental organisations and individuals was that disposing of effluent through deepwater ocean outfalls into strong offshore currents may result in the discharge polluting a long section of coastline³. The Review of Sydney's Beach Protection Program² provided some evidence that faecal contamination may be transported by winds and currents to areas which had been unaffected by sewage

contamination, particularly to the south.

A primary cause for concern is the transportation of "beach grease" which may contain viruses and bacteria. Through their encapsulation in grease balls, pathogens are protected from sunlight and seawater, which usually cause die-off. Grease particles released through the deepwater outfalls will immediately come to the surface. Studies of wind-driven transport of floatables suggest grease particles discharged through the deepwater outfalls could still arrive at Sydney's beaches and be more widespread than before the commissioning of the deepwater outfalls².

Contact with or direct ingestion of small grease particles may present an acute public health hazard. Potential waterborne disease symptoms associated with swimming in faecally contaminated water include:

- gastrointestinal – vomiting, diarrhoea, abdominal pain and nausea;
- respiratory – throat infections, coughs, colds; and
- general – ear and eye infections, skin lesions and fever.

The Sydney Beach Users Study⁴ provided evidence that the risk of illness from swimming increases with

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tracks and other facilities may encourage children away from these areas where collision with pedestrians or motor vehicles may result in injury or death. In the Hunter region councils and in-line skating groups have begun exploring possibilities for safe skating venues. In Eastern Sydney findings of this study are being fed back to local government officials.

PUBLIC HEALTH ACTION AND RECOMMENDATIONS

Public health action in Eastern Sydney has consisted of media releases to inform people of the risk and nature of injuries and to advise skaters to wear protective clothing and avoid skating on roads. Further measures are needed to prevent or reduce injuries and potential deaths from in-line skating and future similar products. They include:

- a mechanism for the independent evaluation of the safety of new consumer goods, particularly those directed at children. The Australian Consumers' Association recommends a national consumer product safety commission to assess and police product safety standards¹³. Such an organisation has been operating in the US since 1973, reportedly substantially reducing injuries and injury deaths¹³;
- the broadening of surveillance data to include product brand information;
- promotion of the usage of protective clothing at points of hire and sale and the provision of safety information (protective clothing usage, speed control, surfaces, legislation) on all product packaging; and
- provision of more designated skating venues to encourage children away from footpaths and roads. Multipurpose venues providing supervision of

children by parents, skating or community groups could be promoted for a range of activities including in-line skating, rollerskating, skateboarding and future recreational/sporting pursuits.

ACKNOWLEDGMENTS

Linda Christie, Project Officer, Injury Surveillance Unit, Prince of Wales Children's Hospital, Sydney; Denise Kaminski, Injury Surveillance Unit, John Hunter Hospital, Newcastle.

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11. Mackenzie J, editor. In-line skates. *Choice* (Sydney: the magazine of the Australian Consumers' Association) 1992; 33(12):23-7.
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13. Mackenzie J, editor. The Australian standard: flag of excellence or compromise? *Choice* 1992; 33(12):28-31.

the laboratory (10 faecal coliforms per 100ml). Similar results were found for faecal streptococci, with 75 per cent of samples below the detection limits of the laboratory (10 faecal streptococci per 100ml).

The wind direction at Sydney Airport during the 1990 survey was predominantly a mild to moderate north-westerly. North-westerly winds occurred on nine days (64 per cent), south-westerly on four days (29 per cent) and north-easterly on one day (7 per cent). Similar results were recorded during the 1993 survey.

Equipment failure meant limited data were available from Wollongong weather station during the 1990 survey. Where data were available, westerly winds predominated. A similar wind pattern was recorded in 1993.

There was no odour or visual evidence of grease, faecal matter or stormwater pollution on any of the 28 days samples were taken during 1990 and 1993.

DISCUSSION

Recreational water at Garie Beach was found to be free from faecal contamination both before and after the commissioning of Sydney's deepwater ocean outfalls. All water samples met the bacteriological standard for tidal waters set by the NSW Health Department. The standard states: "Water should be considered to be unsuitable for bathing where the faecal coliform count, calculated as the geometric mean of the number of organisms in three water samples taken at the same time from the area being examined, exceeds 300 organisms per 100ml, with an upper limit of 2,000 organisms per 100ml (in any one sample)."⁶

The lack of visual sewage pollution on the shore or in the water is consistent with the bacteriological findings.

A major limitation of the survey was the predominant westerly (offshore) winds recorded during the periods of sampling. Sewage floatables like "grease balls" could affect Garie Beach only with moderate to strong north-easterly, onshore winds and favourable current and eddy movements. North-easterly winds were recorded only once during the 1993 sampling program. Westerly winds predominated during the survey period, reducing the likelihood of faecal contamination from the ocean outfalls reaching the beach. Detailed current and eddy data could not be obtained for areas south of Port Hacking. Despite this, the very low levels of faecal indicator organisms and the lack of visual pollution detected during the survey suggest the Sydney deepwater ocean outfalls are unlikely to have had a detrimental impact on the bacteriological water quality at Garie Beach.

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

REDUCTION IN DEATHS FROM ISCHAEMIC HEART DISEASE

Deaths from ischaemic heart disease are falling substantially in many countries. A major public health question is the extent changes in important risk factors influence these trends. Finland has been one of the most active countries in developing and testing preventive measures for cardiovascular disease because in the early 1970s middle-aged Finnish men had the highest mortality from cardiovascular disease in the world. Between 1972 and 1992 mortality in parts of Finland fell by 55 per cent for men and 68 per cent for women. These declines have been almost wholly due to falls in the major risk factors, namely serum cholesterol concentration, elevated blood pressure and smoking.

Vartiainen E, Puska P, Pekkanen J et al. Changes in risk factors explain changes in mortality from ischaemic heart disease in Finland. *Br Med J* 1994; 309:23-7.

ASTHMA RISE IN AUSTRALIAN CHILDREN

A study between 1982 and 1992 in Wagga and Newcastle, NSW, has shown that the prevalence of recent wheeze in children aged 8-10 years rose 1.5 fold to about 25 per cent of all children. The reason for the increase is not known. However, there are higher levels of allergens - the numbers of house dust mites increased five fold during the study - or there may be new and unknown environmental factors.

Peat JK, Ven Den Berg RH, Green WF et al. Changing prevalence of asthma in Australian children. *Br Med J* 1994; 308:1591-6.

ALCOHOL CONSUMPTION AND HIGH BLOOD PRESSURE

It has long been known that there is a strong association between alcohol consumption and blood pressure. A large international study has confirmed this experience and shown that heavy alcohol consumption (three-four or more drinks a day) taken intermittently has a greater impact on blood pressure than constant heavy drinking. But constant heavy drinking also raises blood pressure. The study involved nearly 5,000 men and 5,000 women between 20 and 59 years in 50 centres on a worldwide basis.

Marmot MG, Elliott P, Shipley MJ et al. Alcohol and blood pressure: the INTERSALT study. *Br Med J* 1994; 308:1263-7.

PREVENTION OF SUICIDE: NO CLEAR STRATEGIES

A detailed review of the evidence indicates that no clear strategies are available for combating the increasing numbers of suicides among young people. Possible interventions include education of health care professionals on the recognition and treatment of depression, strengthening schemes to limit the size of individual prescriptions and reinforcement of media guidelines on the reporting and showing of fictional suicide. To understand the problems of rising suicide in youth, research must address the experience of young people and aspects of economic and social policy at a national level, according to the British authors of this paper.

Gunnell D, Frankel S. Prevention of suicide: aspirations and evidence. *Br Med J* 1994; 308:1227-33.

INFECTIOUS DISEASES

SYPHILIS

The notification rate of syphilis increased this year, with 703 cases notified so far in 1994 compared with 554 for the same period in 1993. The increase was limited to the Sydney metropolitan area, in particular Eastern, Central and Southern Sydney. In 87% of syphilis notifications there was no information on the clinical stage of the disease because most notifications come from laboratories, which have no information on the clinical stage. Notifications based only on serology include an unknown proportion of previously treated cases, as some syphilis serology remains positive for life. Notifications where the clinical stage was specified as primary (acquired within 12 months), however, are likely to be incident cases. Syphilis notifications are being followed up by PHUs to determine if the increase in notifications is due to an increase in incidence.

THE SCHOOLGIRL RUBELLA IMMUNISATION PROGRAM

The rubella campaign has completed administering vaccine to year seven girls in all schools in the Western Sydney Area. The reported coverage rate was 91 per cent.

TRIPLE ANTIGEN REMINDER

Triple antigen vaccine has been available to general practitioners free of charge since July 28. The vaccine is available from local councils and hospitals.

INFLUENZA SURVEILLANCE

For the final influenza surveillance report for 1994 we note that influenza activity appears to have peaked in August and to have been in steady decline during September. From our GP sentinel surveillance network the average consultation rate for influenza-like illness (ILI) reported for the first week in October was 1.9 per cent, down from the August peak of 3.7 per cent (Figure 4). Seven PHUs reported data for September, from a total of about 80 doctors and more than 10,000 consultations a week. The highest rate for ILI reported during September was 2.9 per cent of consultations in Western Sydney.

Westmead Hospital ICPMR laboratory virology reports that the rate of influenza virus isolations has decreased markedly in the past month. It reports a total of 47 isolations of influenza A in 1994, all similar to the A/Beijing/32/92 H3N2 which is in the current vaccine. Only two isolations of influenza B have been reported. Westmead Hospital ICPMR serology laboratory and Prince of Wales

serology laboratory also report a marked decrease in detection of influenza antibodies in September.

School absentee rates are monitored through 17 sentinel schools containing about 11,000 students which report to seven PHUs. There has been no marked peak in school absentee rates this year.

HEPATITIS A

South West PHU reported 71 cases of hepatitis A this year, compared with only eight for the same period in 1993. In 1994 information on risk factors is available for 66 notifications (93 per cent). Of those, 10 cases (15 per cent) had attended or worked in a child care facility, or were household contacts of those who had. The remainder had no other known risk factors such as having recently travelled to a high-incidence country or having recently eaten shellfish. These cases have been widely distributed geographically through the districts of Hume, Murray, Riverina and Murrumbidgee, and no common link has been detected. PHU staff are continuing to investigate.

ACUTE EQUINE RESPIRATORY DISTRESS SYNDROME OUTBREAK IN QUEENSLAND

In September and early October a previously unknown virus caused sickness in 18 horses, killing 14, and is believed to have caused sickness in two humans, causing one death. The index case was a mare which became ill on September 7 and died on September 9. The stable owner became sick on September 15 and the 17 horses became ill between September 17 and 22. Most deaths occurred within two-three days of illness onset. All cases had contact with the one stable. The symptoms included shallow breathing, high fever and lethargy, and pulmonary oedema on post-mortem examination. The Australian Animal Health Laboratory at Geelong isolated a virus of the family *Paramyxoviridae*, genus *Morbillivirus*, which is related to the measles and distemper viruses. The purified virus caused the same respiratory distress syndrome when inoculated into two horses experimentally. An antibody test was developed and both the stable owner and a strapper who became ill were shown to have produced an antibody response to the virus. The virus is considered to be poorly contagious, as about 60 horses were potentially exposed and only 18 became ill. Transmission possibly occurs through close contact with infected nasal discharges.

No cases occurred in NSW, although three horses potentially exposed were quarantined. NSW Health was kept informed of developments through the NSW Agriculture and the Queensland Health Departments.

A serological survey is planned to determine the number of horses exposed to the virus.

PNEUMONIC PLAGUE IN INDIA

Late in September an outbreak of pneumonic plague was first reported from Surat in Gujrat State, India.

Pneumonic plague is caused by *Yersinia pestis*, the same bacterium that causes bubonic plague. Bubonic plague is transmitted through the bites of fleas that have bitten infected rats. An early sign of the disease is painful swelling in the lymph nodes nearest the site of the bite. If infection spreads to the lungs this is then called pneumonic plague, which can be spread by droplets, is highly infectious and invariably fatal if untreated. But both forms of plague respond well to antibiotics.

FIGURE 6

INFLUENZA-LIKE ILLNESS NSW



TABLE 4

**SURVEILLANCE OF NON-NOTIFIABLE SEXUALLY TRANSMITTED DISEASES
JANUARY-SEPTEMBER 1994**
(Diagnoses from sexual health centres unless otherwise stated in footnote)

* First diagnosis 1 01/01/94-30/04/94 2 01/01/94-31/01/94 3 1/01/94-31/07/94
4 01/01/94-31/03/94 5 01/01/94-30/09/94 6 01/01/94-31/05/94 7 01/01/94-30/06/94
8 01/01/94-31/08/94 9 No SHC in Region 10 Laboratory and SHC data 01/01/94-
31/08/94 11 No data yet received for 1994

AHS Infection		CSA ¹	SSA ²	ESA ³	SWS ⁴	WSA ⁴ + WEN	NSA ⁵	CCA ⁶	ILL ⁶	HUN ⁷	NC ⁸	ND ⁹	WNSW ⁸	CW ⁹	SW ¹⁰	SE ¹¹	Total
Chlamydia trachomatis	Male	1	-	30	2	6	2	1	4	8	-	5	6	-	3	-	68
	Female	1	-	40	5	7	1	1	4	14	1	18	19	-	8	-	119
	Total	2	-	70	7	13	3	2	8	22	1	23	25	-	11	-	187
Donovanosis	Male	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Female	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
*Genital herpes	Male	3	1	173	3	12	8	12	-	15	7	2	1	-	5	-	242
	Female	4	3	100	5	9	9	11	4	15	9	14	5	-	7	-	195
	Total	7	4	273	8	21	17	23	4	30	16	16	6	-	12	-	437
*Genital warts	Male	11	6	479	69	74	22	35	36	75	33	7	6	-	8	-	861
	Female	8	6	193	32	37	21	20	13	30	11	24	15	-	10	-	420
	Total	19	12	672	101	111	43	55	49	105	44	31	21	-	18	-	1,281
Nongonococcal urethritis	Male	3	1	350	23	55	14	33	10	43	13	8	7	-	4	-	564
	Female	-	-	-	-	3	2	-	-	-	-	-	2	-	2	-	9
	Total	3	1	350	23	58	16	33	10	43	13	8	9	-	6	-	573
Lymphogranuloma venereum	Male	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Female	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Quarantine is a Commonwealth responsibility, and Australia's response to the outbreak was coordinated by the Commonwealth Department of Human Services and Health, with the cooperation of NSW Health and other State health departments. For a two-week period, all passengers returning to Australia who had been in Gujrat or Maharashtra States in the previous week were referred to the Australian Quarantine Inspection Service at the airport, provided with information on the disease and told to see a doctor immediately if symptoms developed. A travel alert was issued advising people against travelling to the affected States. Information on plague, including diagnosis, treatment and prophylaxis, was provided to all general practitioners through the Divisions of General Practice.

In NSW, a contingency plan was prepared in case the situation in India deteriorated. Some elements of the plan were implemented, as mentioned above, and the following steps were to be implemented if the epidemic in India worsened.

- The notification procedure under the Commonwealth Quarantine Act 1908 and the NSW Public Health Act 1991 to be strictly enforced, including the notification of contacts of possible plague cases under the Quarantine Act.
- Intensive identification of suspected cases and proper management of cases and contacts, including the isolation of possible cases. Every effort to be undertaken to trace all possible contacts.
- All potential plague cases to be referred to Westmead Hospital for assessment and treatment where appropriate.

No cases of plague were reported in NSW. Additional quarantine surveillance measures at Australian ports ceased on October 27. However, at the time of going to press, travellers to the Surat District of Gujrat State and the Beed District of Maharashtra State were advised to carry antibiotics, to be taken if they come into contact with a case of plague.

PUBLIC HEALTH EDITORIAL STAFF

The editor of the Public Health Bulletin is Dr Michael Frommer, Acting Director, Research and Development, NSW Health Department; production manager is Marie-Louise Stokes, and assistant editor is Dr Valerie Delpach.

The Bulletin aims to provide its readers with population health data and information to motivate effective public health action. Articles, news and comments should be 1,000 words or less in length and include a summary of the key points to be made in the first paragraph.

Please submit items in hard copy and on diskette, preferably using WordPerfect 5.1, to the editor, NSW Public Health Bulletin, Locked Mail Bag 961, North Sydney 2059. Facsimile (02) 391 9232.

Please contact your local Public Health Unit to obtain copies of the NSW Public Health Bulletin.

TABLE 5
**INFECTIOUS DISEASE NOTIFICATIONS FOR 1994
BY SELECTED MONTH OF ONSET FOR NOTIFICATIONS
RECEIVED BY SEPTEMBER 30, 1994**

Condition	Jun	Jul	Aug	Sep	Total
AIDS	23	28	18	15	84
Arboviral infection	36	7	3	2	48
Brucellosis	-	-	2	-	2
Foodborne illness (NOS)	10	3	2	-	15
Gastroenteritis (instit.)	26	47	34	3	110
Gonorrhoea	23	27	19	9	78
H influenzae epiglottitis	4	-	-	-	4
H influenzae meningitis	4	-	2	1	7
H influenzae septicaemia	2	1	1	-	4
H influenzae infection (NOS)	1	-	-	-	1
Hepatitis A - acute viral	46	38	36	18	138
Hepatitis B - acute viral	6	7	6	-	19
Hepatitis B - chronic/carrier	46	43	37	6	132
Hepatitis B - unspecified	286	293	277	86	942
Hepatitis C - acute viral	-	2	5	1	8
Hepatitis C - unspecified	786	688	718	211	2,403
Hepatitis D - unspecified	2	1	-	-	3
Hepatitis, acute viral (NOS)	-	1	1	1	3
HIV infection	27	32	34	21	114
Hydatid disease	4	2	1	-	7
Legionnaires' disease	8	9	2	-	19
Leprosy	1	-	1	-	2
Leptospirosis	1	-	2	-	3
Listeriosis	-	-	1	1	2
Malaria	20	11	17	6	54
Measles	16	36	34	73	159
Meningococcal meningitis	7	6	16	1	30
Meningococcal septicaemia	3	5	8	2	18
Meningococcal infection (NOS)	2	2	2	2	8
Mumps	1	-	1	-	2
Mycobacterial atypical	29	15	7	-	51
Mycobacterial tuberculosis	26	13	9	6	54
Mycobacterial infection (NOS)	5	13	6	7	31
Pertussis	69	81	95	49	294
Q fever	20	15	6	2	43
Rubella	-	2	1	1	4
Rubella - congenital	-	-	1	-	1
Salmonella (NOS)	48	35	27	9	119
Salmonella bovis morbificans	-	1	1	-	2
Salmonella typhimurium	21	18	15	1	55
Syphilis	75	63	90	30	258
Typhoid and paratyphoid	2	4	3	1	10
Total	1,689	1,552	1,542	565	5,348

TABLE 6
**SUMMARY OF NSW INFECTIOUS DISEASE NOTIFICATIONS
SEPTEMBER 1994**

Condition	Number of cases notified			
	Period		Cumulative	
	Sep 1993	Sep 1994	Sep 1993	Sep 1994
Adverse reaction	7	-	21	24
AIDS	30	15	280	255
Arboviral infection	8	2	612	347
Brucellosis	1	-	4	2
Cholera	-	-	-	-
Diphtheria	-	-	-	-
Foodborne illness (NOS)	16	-	105	124
Gastroenteritis (instit.)	25	3	309	198
Gonorrhoea	20	9	266	230
H influenzae epiglottitis	-	-	30	18
H influenzae B - meningitis	3	1	50	13
H influenzae B - septicaemia	1	-	21	10
H influenzae infection (NOS)	3	-	13	8
Hepatitis A	46	18	467	379
Hepatitis B	391	92	2,950	2,866
Hepatitis C	626	212	4,628	5,727
Hepatitis D	1	-	9	11
Hepatitis, acute viral (NOS)	-	1	6	5
HIV infection	33	21	425	317
Hydatid disease	-	-	1	11
Legionnaires' disease	5	-	52	45
Leprosy	1	-	3	3
Leptospirosis	1	-	12	12
Listeriosis	-	1	6	6
Malaria	16	6	146	148
Measles	405	73	988	454
Meningococcal meningitis	20	1	61	52
Meningococcal septicaemia	3	2	30	27
Meningococcal infection (NOS)	1	2	9	11
Mumps	4	-	6	3
Mycobacterial tuberculosis	33	6	318	214
Mycobacterial - atypical	42	-	298	263
Mycobacterial infection (NOS)	4	7	31	62
Pertussis	210	49	681	952
Plague	-	-	-	-
Poliomyelitis	-	-	-	-
Q fever	31	2	307	167
Rubella	140	1	494	32
Salmonella infection (NOS)	38	10	725	749
Syphilis	54	30	554	703
Tetanus	-	-	5	2
Typhoid and paratyphoid	-	1	19	23
Typhus	-	-	-	-
Viral haemorrhagic fevers	-	-	-	-
Yellow fever	-	-	-	-

Abbreviations used in this Bulletin:

CSA Central Sydney Health Area, SSA Southern Sydney Health Area, ESA Eastern 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, NC North Coast Public Health Unit, ND Northern District Public Health Unit, WNSW Western New South Wales Public Health Unit, CW Central West Public Health Unit, SW South West Public Health Unit, SE South East Public Health Unit, OTH Interstate/Overseas, U/K Unknown, NOS Not Otherwise Stated.

Please note that the data contained in this Bulletin are provisional and subject to change because of late reports or changes in case classification. Data are tabulated where possible by area of residence and by the disease onset date and not simply the date of notification or receipt of such notification.

TABLE 7

INFECTIOUS DISEASE NOTIFICATIONS FOR 1994
BY PUBLIC HEALTH UNIT, RECEIVED BY SEPTEMBER 30, 1994

Condition	CSA	SSA	ESA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NC	ND	WD	CW	SW	SE	U/K	Total
Adverse event after immunisation	-	1	1	2	5	3	-	1	-	-	2	1	-	-	3	5	-	24
AIDS	37	15	92	13	29	16	18	3	8	5	14	3	-	1	1	-	-	255
Arboviral infection	-	3	3	-	-	-	11	3	5	38	191	57	22	3	9	2	-	347
Brucellosis	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	2
Foodborne illness (NOS)	1	10	7	25	14	8	5	13	1	3	24	-	3	7	2	1	-	124
Gastroenteritis (instit)	69	14	-	10	42	19	1	1	-	2	10	-	-	30	-	-	-	198
Gonorrhoea	22	16	94	7	11	1	9	3	7	6	4	17	20	3	6	4	-	230
H. influenzae epiglottitis	1	2	1	2	1	2	2	3	2	-	2	-	-	-	-	-	-	18
H. influenzae meningitis	1	-	-	4	2	-	2	-	-	-	1	-	1	2	-	-	-	13
H. influenzae septicaemia	-	-	-	1	1	-	2	1	-	1	2	-	1	-	-	1	-	10
H. influenzae infection (NOS)	-	-	-	-	1	-	1	3	1	-	1	-	-	-	1	-	-	8
Hepatitis A - acute viral	21	16	40	38	24	6	25	3	6	18	37	43	5	25	71	1	-	379
Hepatitis B - acute viral	4	2	27	3	3	-	-	-	1	2	8	2	4	1	-	3	-	60
Hepatitis B - chronic/carrier	-	-	225	1	98	5	12	13	-	22	21	9	5	6	-	2	-	419
Hepatitis B - unspecified	331	347	80	756	304	19	347	17	49	45	35	10	9	5	26	7	-	2,387
Hepatitis C - acute viral	-	-	-	-	-	-	1	-	-	-	-	-	5	-	1	4	-	11
Hepatitis C - unspecified	635	349	1,061	587	508	102	530	177	273	333	645	104	37	98	147	130	-	5,716
Hepatitis D - unspecified	3	2	2	-	-	-	1	-	-	-	3	-	-	-	-	-	-	11
Hepatitis E - acute viral	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Hepatitis, acute viral (NOS)	-	-	3	-	-	-	-	-	-	1	-	-	-	-	1	-	-	5
HIV infection	47	17	122	16	14	4	16	5	3	7	5	-	-	-	2	1	58	317
Hydatid disease	1	4	2	-	-	-	-	-	1	1	-	-	1	1	-	-	-	11
Legionnaires' disease	3	2	2	7	11	1	9	-	3	5	-	-	-	2	-	-	-	45
Leprosy	-	-	-	3	-	-	-	-	-	-	-	-	-	-	-	-	-	3
Leptospirosis	1	-	-	-	-	-	-	-	-	3	5	2	-	-	1	-	-	12
Listeriosis	-	-	2	-	1	-	-	-	1	1	-	-	1	-	-	-	-	6
Malaria	14	10	14	10	10	3	36	4	6	7	11	8	-	3	5	7	-	148
Measles	28	15	14	26	36	32	23	5	18	33	122	35	30	12	1	24	-	454
Meningococcal meningitis	3	7	2	7	4	2	4	3	4	5	3	1	2	2	1	2	-	52
Meningococcal septicaemia	1	4	1	6	2	-	4	1	1	5	2	-	-	-	-	-	-	27
Meningococcal infection (NOS)	-	1	-	1	2	-	-	-	-	-	-	-	4	2	1	-	-	11
Mumps	-	-	1	1	-	-	-	-	-	-	-	1	-	-	-	-	-	3
Mycobacterial atypical	45	18	72	21	10	13	30	7	1	29	12	2	-	1	2	-	-	263
Mycobacterial tuberculosis	26	37	21	42	29	3	20	1	9	9	4	4	2	1	6	-	-	214
Mycobacterial infection (NOS)	4	1	6	3	7	1	28	-	-	1	4	2	2	-	3	-	-	62
Pertussis	19	72	53	59	92	31	53	13	45	45	392	21	20	15	6	16	-	952
Q fever	2	2	-	1	1	1	-	1	-	21	23	49	46	15	4	1	-	167
Rubella	-	-	3	-	9	1	4	1	-	-	4	6	1	-	3	-	-	32
Rubella - congenital	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	2
Salmonella (NOS)	20	38	32	45	35	20	48	16	9	28	61	30	24	11	20	6	-	443
Salmonella bovis morbiticans	-	2	1	1	1	2	2	-	1	2	-	-	-	-	-	-	-	12
Salmonella typhimurium	22	25	16	10	51	14	36	14	18	22	12	11	9	10	22	2	-	294
Syphilis	102	44	187	100	40	4	49	10	11	5	29	31	76	7	5	3	-	703
Tetanus	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	2
Typhoid and paratyphoid	5	2	3	2	3	1	1	-	-	-	1	3	-	-	-	2	-	23

TABLE 8

SELECTED INFECTIOUS DISEASE NOTIFICATIONS FOR 1994
BY PUBLIC HEALTH UNIT, RECEIVED BY SEPTEMBER 30, 1994

Condition	CSA	SSA	ESA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NC	ND	WD	CW	SW	SE	U/K	Total
Adverse event after immunisation	-	1	1	2	5	3	-	1	-	-	2	1	-	-	3	5	-	24
H. influenzae epiglottitis	1	2	1	2	1	2	2	3	2	-	2	-	-	-	-	-	-	18
H. influenzae meningitis	1	-	-	4	2	-	2	-	-	-	1	-	1	2	-	-	-	13
H. influenzae septicaemia	-	-	-	1	1	-	2	1	-	1	2	-	1	-	-	1	-	10
H. influenzae infection (NOS)	-	-	-	-	1	-	1	3	1	-	1	-	-	-	1	-	-	8
Measles	28	15	14	26	36	32	23	5	18	33	122	35	30	12	1	24	-	454
Mumps	-	-	1	1	-	-	-	-	-	-	1	-	-	-	-	-	-	3
Pertussis	19	72	53	59	92	31	53	13	45	45	392	21	20	15	6	16	-	952
Rubella	-	-	3	-	9	1	4	1	-	-	4	6	1	-	3	-	-	32
Tetanus	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	2

TABLE 9

FOODBORNE INFECTIOUS DISEASE NOTIFICATIONS FOR 1994
BY PUBLIC HEALTH UNIT, RECEIVED BY SEPTEMBER 30, 1994

Condition	CSA	SSA	ESA	SWS	WSA	WEN	NSA	CCA	ILL	HUN	NC	ND	WD	CW	SW	SE	U/K	Total
Foodborne illness (NOS)	1	10	7	25	14	8	5	13	1	3	24	-	3	7	2	1	-	124
Gastroenteritis (instit.)	69	14	-	10	42	19	1	1	-	2	10	-	-	30	-	-	-	198
Hepatitis A - acute viral	21	16	40	38	24	6	25	3	6	18	37	43	5	25	71	1	-	379
Listeriosis	-	-	2	-	1	-	-	-	1	1	-	-	1	-	-	-	-	6
Salmonella (NOS)	20	38	32	45	35	20	48	16	9	28	61	30	24	11	20	6	-	443
Salmonella bovis morbiticans	-	2	1	1	1	2	2	-	1	2	-	-	-	-	-	-	-	12
Salmonella typhimurium	22	25	16	10	51	14	36	14	18	22	12	11	9	10	22	2	-	294
Typhoid and paratyphoid	5	2	3	2	3	1	1	-	-	-	1	3	-	-	-	2	-	23

NEWS AND COMMENT

EARLY WARNING SYSTEM FOR SUSPICIOUS OR EXCESSIVE PRESCRIBING OF DRUGS OF ADDICTION

Barry Mewes, Chief Pharmacist
Pharmaceutical Services Branch
NSW Health Department

A protocol has been developed to assist in the identification of suspicious or excessive prescribing of Schedule 8 drugs (Drugs of Addiction) in private practice to facilitate early intervention. While the protocol focuses on Schedule 8 drugs, it would be reasonable for it to be applied to all drugs of dependence. It has already been promulgated widely to the medical and pharmaceutical professions.

Abuse of prescription drugs included in Schedule 8 of the NSW Poisons List, such as pethidine, morphine, methadone (Physeptone) and oxycodone (Endone), is of ongoing concern. These drugs are often obtained by "patients" who shop around to find doctors they can persuade to prescribe for them. The "patients" may be dependent on drugs initially prescribed for the treatment of a medical condition or may have a dependence acquired primarily through the use of illegal drugs such as heroin. They are skilful and experienced operators who have become expert in describing appropriate symptoms and can anticipate and convincingly respond to questions asked about their ailments. Alternatively, the patients may admit addiction and persuade doctors to prescribe narcotic drugs to help prevent or ease withdrawal symptoms.

Guidelines to assist doctors to recognise and deal with possible impositions to obtain prescriptions for drugs of addiction have been developed by the Pharmaceutical Services Branch of the NSW Health Department and will be published in a subsequent issue of this *Bulletin*.

Also of concern is self-administration of these drugs by doctors. Self-administration for non-medical reasons is a disturbingly frequent problem and generally leads to the doctor becoming drug dependent.

The following protocol, designed to address all these situations, has been developed by a group which was convened and chaired by the NSW Branch of the Australian Medical Association and included representatives from the Royal Australian College of General Practitioners, Royal Australian College of Physicians, Royal Australian College of Surgeons (Faculty of Anaesthetics), Pharmacy Guild, Pharmacy Board, Pharmaceutical Society and the Pharmaceutical Services Branch of the NSW Health Department.

1. Where a pharmacist becomes aware that a doctor's total prescribing of Schedule 8 preparations has exceeded 20 ampoules and/or 10 prescriptions for an oral preparation (other than codeine) in any one month, without, to the pharmacist's knowledge, the authority of the NSW Health Department, the pharmacist should forthwith notify Barry Mewes, Chief Pharmacist or John Lumby, Deputy Chief Pharmacist at the Pharmaceutical Services Branch (PSB) of the NSW Health Department on (02) 887-5678.
2. Pharmacists should be particularly alert if the drugs are collected by the doctor or a member of the doctor's family or staff, if the drugs are sent to the surgery, or if

they are collected by any person other than the patient (or the patient's nominated agent).

3. Where the pharmacist is concerned about injectable or oral preparations, even when the above quantities have not been reached, the pharmacist should consider notification.
4. On receipt of the notification, the Chief Pharmacist or the Deputy Chief Pharmacist may make inquiries to establish any grounds for concern. Where the inquiries suggest self-administration by the doctor, several organisations, including the Doctor's Health Advisory Service, are available for help.
5. The PSB will not, in any dealings with a doctor, reveal the identity of the notifying pharmacist.
6. Within two months of taking action under 4 (above), the PSB will check with the notifying pharmacists to ascertain whether there has been any change in the doctor's prescribing pattern.
7. Remedial action, where indicated, other than when self-administration is involved (see point 4), will always involve education of the doctor on the appropriate prescribing and use of Schedule 8 drugs.

TABLE 10

PUBLIC HEALTH OFFICER PLACEMENTS

Year of training	Public Health Officer	Placement August '94-February '95
1st	Jeannine Liddle	Western Sector Public Health Unit
	Veth Guevarra	AIDS/Infectious Diseases Branch
	Suzanne Blogg	Health Promotion (Central Office)
	James Blogg	Policy and Planning Division (Central Office)
	Tony Butler	Hunter PHU/Eastern Sydney PHU
	Stephen Hooppell	Central Coast PHU/Northern Sydney PHU
	Gerard Fitzsimmons	AIDS/Infectious Diseases Branch
	Hugh Burke Valerie Delpech	Far West District Maternal and Child Health Unit (Central Office)
2nd	Jennifer Chipps	Environmental Health, Food and Nutrition Branch (Central Office)
	Magnolia Cardona	Western Sector PHU/Western Districts PHU
	Leena Gupta	Policy and Planning Division (Central Office)/Health Services Evaluation Unit (Central Office)
	Bernie Towler	Western Districts PHU
3rd	Cait Lonie Justine Waters	Injury Unit (Central Office) Health Outcomes Policy and Development Branch (Central Office)