Additional reports

Australian Sentinel Practice Research Network

The Research and Health Promotion Unit of the Royal Australian College of General Practitioners operates the Australian Sentinel Practice Research Network (ASPREN). ASPREN is a network of general practitioners who report presentations of defined medical conditions each week. The aim of ASPREN is to provide an indicator of the burden of disease in the primary health setting and to detect trends in consultation rates.

There are currently about 40 general practitioners participating in the network from all states and territories. Seventy-five per cent of these are in metropolitan areas and the remainder are rural based. Between 3,000 and 4,000 consultations are recorded each week.

The list of conditions is reviewed annually by the ASPREN management committee and an annual report is published.

In 2006, six conditions are being monitored, four of which are related to communicable diseases. These include influenza, gastroenteritis, varicella and shingles. Definitions of these conditions were published in Commun Dis Intell 2007;31:162.

Data on influenza-like illness and gastroenteritis from 1 October to 31 December 2006 compared with 2005 are shown as the rate per 1,000 consultations in Figures 1 and 2, respectively.

Children immunisation coverage

Tables 1, 2 and 3 provide the latest quarterly report on childhood immunisation coverage from the Australian Childhood Immunisation Register (ACIR).

The data show the percentage of children fully immunised at 12 months of age for the cohort born between 1 July to 30 September 2005, at 24 months of age for the cohort born between 1 July to 30 September 2004, and at 6 years of age for the cohort born between 1 July to 30 September 2000 according to the National Immunisation Program Schedule.

For information about the Australian Childhood Immunisation Register see Surveillance systems reported in CDI, published in Commun Dis Intell 2007;31:165 and for a full description of the methodology used by the Register see Commun Dis Intell 1998;22:36-37.

Commentary on the trends in ACIR data is provided by the National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases (NCIRS). For further information please contact the NCIRS at telephone +61 2 9845 1435, Email: brynleyh@chw.edu.au.

Reporting period 1 July to 30 September 2006

Immunisation coverage for children ‘fully immunised’ at 12 months of age for Australia increased marginally by 0.4 percentage points to 91.2% (Table 1), whilst there were no important changes in coverage for all individual vaccines due at 12 months of age. There were no significant movements in coverage for individual vaccines by state or territory.

Immunisation coverage for children ‘fully immunised’ at 24 months of age for Australia increased marginally from the last quarter by 0.2 percentage points to 92.4% (Table 2). There were no significant changes in coverage in any jurisdiction for ‘fully
Table 3 shows immunisation coverage estimates for children at 6 years of age for Australia and by state or territory. For the second consecutive quarter, ‘fully immunised’ coverage for Australia increased significantly by 1.8 percentage points (a total increase of 5.3 percentage points in 2 quarters) and is now at the highest level ever recorded since coverage at 6 years of age was first reported in early 2003. Coverage increased in all jurisdictions and for all individual vaccines with the greatest increase in the Northern Territory and Western Australia, by 5.9 and 4 percentage points, respectively. A possible factor in this increase in coverage at 6 years of age is the introduction of the multi-valent combination vaccine DTP-IPV onto the schedule in November 2005, reducing the number of vaccines to be recorded from three to two. Other factors which may have had an impact at the local level include promotional campaigns centred around child care or school entry, or data cleaning activities.

Table 1. Percentage of children immunised at 1 year of age, preliminary results by disease and state or territory for the birth cohort 1 July to 30 September 2005; assessment date 31 December 2006

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>State or territory</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>Qld</th>
<th>SA</th>
<th>Tas</th>
<th>Vic</th>
<th>WA</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children</td>
<td></td>
<td>1,071</td>
<td>23,311</td>
<td>909</td>
<td>14,333</td>
<td>4,550</td>
<td>1,564</td>
<td>16,508</td>
<td>6,745</td>
<td>68,991</td>
</tr>
<tr>
<td>Diphtheria, tetanus, pertussis (%)</td>
<td></td>
<td>92.2</td>
<td>92.0</td>
<td>92.8</td>
<td>91.4</td>
<td>92.1</td>
<td>94.3</td>
<td>92.9</td>
<td>90.8</td>
<td>92.0</td>
</tr>
<tr>
<td>Poliomyelitis (%)</td>
<td></td>
<td>92.2</td>
<td>91.8</td>
<td>92.8</td>
<td>91.4</td>
<td>92.0</td>
<td>94.0</td>
<td>92.8</td>
<td>90.8</td>
<td>92.0</td>
</tr>
<tr>
<td><em>Haemophilus influenzae</em> type b (%)</td>
<td></td>
<td>96.1</td>
<td>95.3</td>
<td>96.4</td>
<td>93.7</td>
<td>94.8</td>
<td>96.4</td>
<td>95.1</td>
<td>94.5</td>
<td>94.8</td>
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<tr>
<td>Hepatitis B (%)</td>
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<td>96.1</td>
<td>95.3</td>
<td>96.6</td>
<td>93.5</td>
<td>94.5</td>
<td>96.4</td>
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<td>Fully immunised (%)</td>
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<td>92.3</td>
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<td>91.1</td>
<td>94.0</td>
<td>91.7</td>
<td>90.2</td>
<td>91.2</td>
</tr>
<tr>
<td>Change in fully immunised since last quarter (%)</td>
<td></td>
<td>+1.2</td>
<td>+0.6</td>
<td>+1.7</td>
<td>-0.3</td>
<td>+0.6</td>
<td>+0.2</td>
<td>+0.3</td>
<td>+0.9</td>
<td>+0.4</td>
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Table 2. Percentage of children immunised at 2 years of age, preliminary results by disease and state or territory for the birth cohort 1 July to 30 September 2004; assessment date 31 December 2006

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>State or territory</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>Qld</th>
<th>SA</th>
<th>Tas</th>
<th>Vic</th>
<th>WA</th>
<th>Aust</th>
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</thead>
<tbody>
<tr>
<td>Total number of children</td>
<td></td>
<td>1,077</td>
<td>22,296</td>
<td>844</td>
<td>13,513</td>
<td>4,330</td>
<td>1,509</td>
<td>16,194</td>
<td>6,505</td>
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<td>Diphtheria, tetanus, pertussis (%)</td>
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<td>95.5</td>
<td>95.0</td>
<td>96.7</td>
<td>94.7</td>
<td>94.9</td>
<td>97.0</td>
<td>96.1</td>
<td>94.0</td>
<td>95.2</td>
</tr>
<tr>
<td>Poliomyelitis (%)</td>
<td></td>
<td>95.5</td>
<td>94.9</td>
<td>96.5</td>
<td>94.6</td>
<td>94.9</td>
<td>97.0</td>
<td>96.0</td>
<td>94.0</td>
<td>95.1</td>
</tr>
<tr>
<td><em>Haemophilus influenzae</em> type b (%)</td>
<td></td>
<td>94.9</td>
<td>93.7</td>
<td>95.1</td>
<td>93.5</td>
<td>93.7</td>
<td>96.0</td>
<td>94.8</td>
<td>92.7</td>
<td>93.9</td>
</tr>
<tr>
<td>Measles, mumps, rubella (%)</td>
<td></td>
<td>94.5</td>
<td>93.7</td>
<td>96.2</td>
<td>93.5</td>
<td>93.9</td>
<td>95.0</td>
<td>95.0</td>
<td>92.7</td>
<td>94.0</td>
</tr>
<tr>
<td>Hepatitis B (%)</td>
<td></td>
<td>95.9</td>
<td>95.8</td>
<td>97.5</td>
<td>95.5</td>
<td>95.9</td>
<td>97.2</td>
<td>96.4</td>
<td>94.7</td>
<td>95.8</td>
</tr>
<tr>
<td>Fully immunised (%)</td>
<td></td>
<td>93.5</td>
<td>92.1</td>
<td>94.4</td>
<td>91.8</td>
<td>92.4</td>
<td>94.5</td>
<td>93.6</td>
<td>90.8</td>
<td>92.4</td>
</tr>
<tr>
<td>Change in fully immunised since last quarter (%)</td>
<td></td>
<td>-0.3</td>
<td>+0.7</td>
<td>-0.1</td>
<td>+0.2</td>
<td>+1.2</td>
<td>+0.7</td>
<td>-0.0</td>
<td>-0.5</td>
<td>+0.2</td>
</tr>
</tbody>
</table>

* The 12 months age data for this cohort was published in Commun Dis Intell 2006;30:157.
Table 3. Percentage of children immunised at 6 years of age, preliminary results by disease and state or territory for the birth cohort 1 July to 30 September 2000; assessment date 31 December 2006

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>Qld</th>
<th>SA</th>
<th>Tas</th>
<th>Vic</th>
<th>WA</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children</td>
<td>1,064</td>
<td>22,649</td>
<td>815</td>
<td>13,963</td>
<td>4,599</td>
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<td>16,277</td>
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<td>Diphtheria, tetanus, pertussis (%)</td>
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<td>88.8</td>
<td>88.8</td>
<td>88.4</td>
<td>87.6</td>
<td>89.9</td>
<td>90.8</td>
<td>85.6</td>
<td>88.8</td>
</tr>
<tr>
<td>Poliomyelitis (%)</td>
<td>90.1</td>
<td>88.7</td>
<td>88.8</td>
<td>88.6</td>
<td>87.5</td>
<td>89.9</td>
<td>90.8</td>
<td>85.6</td>
<td>88.8</td>
</tr>
<tr>
<td>Measles, mumps, rubella (%)</td>
<td>90.2</td>
<td>88.8</td>
<td>88.8</td>
<td>88.6</td>
<td>87.2</td>
<td>89.7</td>
<td>90.8</td>
<td>85.6</td>
<td>88.8</td>
</tr>
<tr>
<td>Fully immunised (%)</td>
<td>89.4</td>
<td>87.9</td>
<td>88.1</td>
<td>87.6</td>
<td>86.6</td>
<td>89.3</td>
<td>90.1</td>
<td>84.7</td>
<td>88.0</td>
</tr>
<tr>
<td>Change in fully immunised since last quarter (%)</td>
<td>+1.8</td>
<td>+1.7</td>
<td>+5.9</td>
<td>+1.4</td>
<td>+2.0</td>
<td>+0.7</td>
<td>+1.1</td>
<td>+4.0</td>
<td>+1.8</td>
</tr>
</tbody>
</table>

Figure 3 shows the trends in vaccination coverage from the first ACIR-derived published coverage estimates in 1997 to the current estimates. There is a clear trend of increasing vaccination coverage over time for children aged 12 months, 24 months and 6 years, although the rate of increase has slowed over the past 2 years for all age groups. The recent increase in coverage at 6 years of age, described in the previous paragraph, is apparent in the Figure. It should be noted that, currently, coverage for the vaccines added to the National Immunisation Program since 2003 (pneumococcal conjugate at 2, 4 and 6 months; meningococcal C conjugate at 12 months; and varicella at 18 months) are not included in the coverage estimates at 12 or 24 months of age.

Gonococcal surveillance

John Tapsall, The Prince of Wales Hospital, Randwick NSW 2031 for the Australian Gonococcal Surveillance Programme.

The Australian Gonococcal Surveillance Programme (AGSP) reference laboratories in the various States and Territories report data on sensitivity to an agreed 'core' group of antimicrobial agents quarterly. The antibiotics currently routinely surveyed are penicillin, ceftriaxone, ciprofloxacin and spectinomycin, all of which are administered as single dose regimens and currently used in Australia to treat gonorrhoea. When in vitro resistance to a recommended agent is demonstrated in 5% or more of isolates from a general population, it is usual to remove that agent from the list of recommended treatment. Additional data are also provided on other antibiotics from time to time. At present all laboratories also test isolates for the presence of high level (plasmid-mediated) resistance to the tetracyclines, known as TRNG. Tetracyclines are however, not a recommended therapy for gonorrhoea in Australia. Comparability of data is achieved by means of a standardised system of testing and a program-specific quality assurance process. Because of the substantial geographic differences in susceptibility patterns in Australia, regional as well as aggregated data are presented. For more information see Commun Dis Intell 2007;31:163.

Reporting period 1 July to 30 September 2006

The AGSP laboratories received a total of 869 gonococcal isolates of which 854 remained viable for susceptibility testing. This was about 10% less than the 968 gonococci reported for the same period in 2005. About one third of this total was from New South Wales, 21% from Victoria, 16% each from the Northern Territory and Queensland, 11% from Western Australia and 5% from South Australia. There were 2 isolates each from Tasmania and the Australian Capital Territory.
Penicillins

In this quarter, 303 (35.5%) of the 854 isolates examined were penicillin resistant by one or more mechanisms. Seventy-six (8.9%) were penicillinase producing *N. gonorrhoeae* (PPNG) and 227 (26.6%) resistant by chromosomal mechanisms, (CMRNG). The proportion of all strains resistant to the penicillins by any mechanism ranged from 4.3% in the Northern Territory to 50% in New South Wales and Victoria. High rates of penicillin resistance were also found in South Australia (37.8%) and Queensland (31%), with a lower rate (13.4%) in Western Australia.

Figure 4 shows the proportions of gonococci fully sensitive (MIC ≤ 0.03 mg/L), less sensitive (MIC 0.06–0.5 mg/L), relatively resistant (MIC ≥1 mg/L) or else penicillinase producing (PPNG) aggregated for Australia and by state or territory. A high proportion those strains classified as PPNG or else resistant by chromosomal mechanisms fail to respond to treatment with penicillins (penicillin, amoxycillin, ampicillin) and early generation cephalosporins.

In New South Wales, most of the penicillin resistance was due to CMRNG (117, 42.4%) with 21 PPNG (7.6%). A similar distribution was present in Victoria with 20 PPNG (11%) and 70 CMRNG (38.7%). This disparity was not quite as pronounced in other centres. The proportion of CMRNG in Queensland increased to 17% while 14% were PPNG. In South Australia, 16% were PPNG and 21% were CMRNG. In Western Australia, PPNG and CMRNG each accounted for 6.7% of all 89 isolates. PPNG were also present in Tasmania and the Northern Territory (1 and 4 isolates respectively). No PPNG were detected in the Australian Capital Territory. CMRNG were present in Tasmania (1 isolate), the Northern Territory (2) and there was a single CMRNG from the Australian Capital Territory.

Ceftriaxone

Four isolates with decreased susceptibility to ceftriaxone (MIC range 0.06–0.12 mg/L) were detected. Three were found in Queensland and 1 in New South Wales. All 4 isolates were penicillin resistant by chromosomal mechanisms and were also quinolone resistant (ciprofloxacin MICs 4–16 mg/L). It is emphasised that no treatment failures have been documented locally when a 250 mg IM dose of ceftriaxone has been used.

Spectinomycin

All isolates susceptible to this injectable agent.

Quinolone antibiotics

The number (325) and percentage (38%) of quinolone resistant *N. gonorrhoeae* (QRNG) detected in this quarter was the highest proportion of QRNG found in this program to date. In the third quarter of 2004 there were 200 QRNG; 24% of all gonococci tested, and in this quarter in 2005, the number (335) was higher but the proportion (35.5%) slightly lower. The majority of QRNG (317 of 325, 97.5%) exhibited higher-level resistance to ciprofloxacin of 1 mg/L or more. QRNG are defined as those isolates with an MIC to ciprofloxacin equal to or greater than 0.06 mg/L. QRNG are further subdivided into less sensitive (ciprofloxacin MICs 0.06–0.5 mg/L) or resistant (MIC ≥ 1 mg/L) groups.

QRNG were detected in all states and territories (Figure 5). The highest proportion of QRNG was found in Victoria where 96 QRNG accounted for 53% of all gonococci tested. In South Australia, there were 17 QRNG (46% of isolates), in New South Wales 146 QRNG (52.8%), Queensland 44 (34%), Western Australia 13 (14.6%), with 6 QRNG detected in the Northern Territory, 2 in Tasmania and 1 in the Australian Capital Territory.

High level tetracycline resistance

The number (102) and proportion (11.9%) of high level tetracycline resistant *N. gonorrhoeae* (TRNG) detected was lower than that recorded in this quarter in 2005 (156, 16.6%). TRNG were found in all states and territories except for Tasmania and the Australian Capital Territory and represented between 5% (Northern Territory) and 26% of isolates (Western Australia).
Scientists, diagnostic and reference laboratories contribute data to NEPSS, which is supported by state and territory health departments and the Australian Government Department of Health and Ageing.

Reports to the National Enteric Pathogens Surveillance System of Salmonella infection for the period 1 October to 31 December 2006 are included in Tables 6 and 7. Data include cases reported and entered by 19 January 2006. Counts are preliminary, and subject to adjustment after completion of typing and reporting of further cases to NEPSS. For more information see Commun Dis Intell 2007;31:164–165.

Reporting period 1 October to 30 September 2006

There were 1,873 reports to NEPSS of human Salmonella infection in the fourth quarter of 2006; 64% more than in third quarter of 2006, and around 10% more than the 10-year historical mean for this period. An increase in reports of both sporadic and outbreak-associated human salmonellosis from late spring through summer is typical of seasonal trends in the incidence of salmonellosis in Australia.

During the fourth quarter of 2006, the 25 most common Salmonella types in Australia accounted for 1,243 cases; 66% of all reported human Salmonella infections. Nineteen of the 25 most common Salmonella infections in the fourth quarter of 2006 were also among those most commonly reported in preceding quarter.

S. Saintpaul was by far the most common Salmonella in Australia, with the recent excess of cases largely due to widespread outbreaks associated with fresh produce. S. Typhimurium phage types 170, 135 and 44 were next most common, particularly in New South Wales and Victoria. S. Typhimurium phage type 170 emerged in late 2001, and despite declining markedly each winter, reappears regularly as a prominent cause of human disease during the warmer months. The increase in S. Typhimurium phage type 44 cases is more recent.

Other salmonellae manifesting increases over the recent historical average include S. Typhimurium phage type 197 (in Queensland), S. Montevideo and S. Wangata (New South Wales), S. Litchfield (Western Australia) and S. Havana (New South Wales).

Acknowledgement: We thank scientists, contributing laboratories, state and territory health departments, and the Australian Government Department of Health and Ageing for their contributions to NEPSS.
### Table 6: Top 25 Salmonella types identified in Australia, 1 October to 31 December 2006, by state or territory

<table>
<thead>
<tr>
<th>National rank</th>
<th>Salmonella type</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>Qld</th>
<th>SA</th>
<th>Tas</th>
<th>Vic</th>
<th>WA</th>
<th>Total 4th quarter 2006</th>
<th>Last 10 years mean 4th quarter</th>
<th>Year to date 2006</th>
<th>Year to date 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>S. Saintpaul</td>
<td>10</td>
<td>81</td>
<td>9</td>
<td>79</td>
<td>1</td>
<td>7</td>
<td>44</td>
<td>7</td>
<td>238</td>
<td>78</td>
<td>561</td>
<td>437</td>
</tr>
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<td>15</td>
<td>0</td>
<td>47</td>
<td>2</td>
<td></td>
<td>134</td>
<td>61</td>
<td>409</td>
<td>472</td>
</tr>
<tr>
<td>3</td>
<td>S. Typhimurium PT 135</td>
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<td>5</td>
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<td>667</td>
<td>805</td>
</tr>
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<td>61</td>
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</tr>
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<td>0</td>
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<td>18</td>
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<td>17</td>
<td>11</td>
<td>42</td>
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<tr>
<td>24</td>
<td>S. Singapore</td>
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<td>11</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>16</td>
<td>13</td>
<td>54</td>
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<td>5</td>
<td>5</td>
<td>15</td>
<td>8</td>
<td>52</td>
<td>90</td>
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</table>
HIV and AIDS surveillance

National surveillance for HIV disease is coordinated by the National Centre in HIV Epidemiology and Clinical Research (NCHECR), in collaboration with State and Territory health authorities and the Commonwealth of Australia. Cases of HIV infection are notified to the National HIV Database on the first occasion of diagnosis in Australia, by either the diagnosing laboratory (Australian Capital Territory, New South Wales, Tasmania, Victoria) or by a combination of laboratory and doctor sources (Northern Territory, Queensland, South Australia, Western Australia). Cases of AIDS are notified through the State and Territory health authorities to the National AIDS Registry. Diagnoses of both HIV infection and AIDS are notified with the person’s date of birth and name code, to minimise duplicate notifications while maintaining confidentiality.


HIV and AIDS diagnoses and deaths following AIDS reported for 1 July to 30 September 2006, as reported to 30 December 2006, are included in this issue of Communicable Diseases Intelligence (Tables 4 and 5).

Table 4. New diagnoses of HIV infection, new diagnoses of AIDS and deaths following AIDS occurring in the period 1 July to 30 September 2006, by sex and state or territory of diagnosis

<table>
<thead>
<tr>
<th></th>
<th>State or territory</th>
<th>This period 2006</th>
<th>This period 2005</th>
<th>YTD 2006</th>
<th>YTD 2005</th>
</tr>
</thead>
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<td>ACT</td>
<td>NSW</td>
<td>NT</td>
<td>Qld</td>
<td>SA</td>
</tr>
<tr>
<td>Female</td>
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<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>41</td>
<td>0</td>
<td>31</td>
<td>1</td>
</tr>
<tr>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total*</td>
<td>0</td>
<td>42</td>
<td>0</td>
<td>38</td>
<td>1</td>
</tr>
</tbody>
</table>

| AIDS diagnoses | ACT | NSW | NT | Qld | SA | Tas | Vic | WA |        |        |        |        |
| Female | 0   | 0   | 0  | 1   | 0  | 0   | 3   | 1  | 5      | 11     | 15     | 26     |
| Male   | 0   | 17  | 0  | 3   | 2  | 0   | 19  | 2  | 43     | 43     | 119    | 137    |
| Total* | 0   | 17  | 0  | 4   | 2  | 0   | 23  | 3  | 49     | 54     | 136    | 163    |

| AIDS deaths | ACT | NSW | NT | Qld | SA | Tas | Vic | WA |        |        |        |        |
| Female | 0   | 0   | 0  | 0   | 0  | 0   | 0   | 0  | 0      | 1      | 3      | 3      |
| Male   | 0   | 6   | 0  | 2   | 2  | 0   | 10  | 0  | 20     | 17     | 49     | 45     |
| Total* | 0   | 6   | 0  | 2   | 2  | 0   | 10  | 0  | 20     | 18     | 54     | 48     |

* Totals include people whose sex was reported as transgender.
Table 5. Cumulative diagnoses of HIV infection, AIDS, and deaths following AIDS since the introduction of HIV antibody testing to 30 September 2006, and reported by 31 December 2006, by sex and state or territory

<table>
<thead>
<tr>
<th>Sex</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>Qld</th>
<th>SA</th>
<th>Tas</th>
<th>Vic</th>
<th>WA</th>
<th>Australia</th>
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<td>HIV diagnoses</td>
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<td></td>
</tr>
<tr>
<td>Female</td>
<td>32</td>
<td>844</td>
<td>18</td>
<td>261</td>
<td>94</td>
<td>8</td>
<td>356</td>
<td>203</td>
<td>1,816</td>
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<tr>
<td>Male</td>
<td>259</td>
<td>13,301</td>
<td>128</td>
<td>2,685</td>
<td>899</td>
<td>95</td>
<td>5,187</td>
<td>1,202</td>
<td>23,756</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>22</td>
<td>0</td>
<td>253</td>
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<tr>
<td>Total*</td>
<td>291</td>
<td>14,405</td>
<td>146</td>
<td>2,955</td>
<td>994</td>
<td>103</td>
<td>5,587</td>
<td>1,412</td>
<td>25,893</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>43</td>
<td>1,022</td>
<td>399</td>
<td>50</td>
<td>1,984</td>
<td>423</td>
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<tr>
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<td>5,642</td>
<td>46</td>
<td>1,094</td>
<td>432</td>
<td>54</td>
<td>2,106</td>
<td>463</td>
<td>9,940</td>
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<tr>
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<td>292</td>
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<tr>
<td>Male</td>
<td>74</td>
<td>3,572</td>
<td>26</td>
<td>661</td>
<td>276</td>
<td>32</td>
<td>1,410</td>
<td>292</td>
<td>6,343</td>
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<tr>
<td>Total*</td>
<td>81</td>
<td>3,719</td>
<td>27</td>
<td>705</td>
<td>296</td>
<td>34</td>
<td>1,479</td>
<td>317</td>
<td>6,658</td>
</tr>
</tbody>
</table>

* Totals include people whose sex was reported as transgender.

OVERSEAS BRIEFS

Reporting period 1 October to 31 December 2006

Avian influenza

The World Health Organization (WHO) confirmed 11 cases of avian influenza (H5N1) in humans including 9 deaths between 1 October and 31 December 2006, bringing the total number of WHO-confirmed cases for 2006 to 116 including 80 deaths.

There was no evidence of human-to-human transmission of avian influenza during the reporting period. The Egyptian (4) and Indonesian (6) cases were all known to have had exposure to, or close contact with sick poultry. The Chinese (1) case kept domestic poultry but the health status of the birds is unclear.

Since the beginning of the current outbreak of avian influenza in November 2003, peak incidence has generally occurred between January and April, therefore a rise in the number of confirmed cases could be expected in the first quarter of 2007.

Chikungunya

Outbreaks of chikungunya were reported from Sri Lanka and the Maldives between October and December 2006, following major outbreaks in neighbouring India and a number of Indian Ocean islands earlier in the year. Sri Lanka reported 5,000 suspected cases in November (confirmation of the presence of the virus was obtained for 5 blood samples). Between early November and 19 December 2006, 135 suspected cases were also reported from the Maldives. In 2006, there were no deaths directly attributable to chikungunya infection confirmed by the WHO anywhere in the world.

Imported cases of chikungunya were reported in the United Kingdom (106 between January and October 2006), Taiwan (1), the United States of America (28) and Spain (7) in 2006. Most cases were linked to travel to known chikungunya endemic areas, although the case that was imported to Taiwan was reportedly from Singapore, where no recent chikungunya outbreaks have been recorded.

Cholera

WHO estimates that the officially reported cases of cholera represent around 5–10% of actual cases worldwide due to widespread under-reporting and poor surveillance systems. During the reporting period, new and continuing outbreaks of cholera or watery diarrhoeal syndrome were reported from China, India and a number of African countries: Angola, Burundi, Chad, Democratic Republic of the Congo, Ethiopia, Guinea, Kenya, Liberia, Malawi, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Uganda and Zambia. All of these countries reported outbreaks of cholera during 2005 with the exceptions of Angola, Ethiopia, Somalia and Sudan, which did not record significant outbreaks between 2000 and 2005, but are all considered cholera-endemic.