investigation. We also appreciate the discussions and input by John Piispanen, Tropical Public Health Unit, Townsville.

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Dengue in Queensland

Queensland Health's Tropical Public Health Unit has reported 40 confirmed and 15 probable cases of dengue fever in Cairns, up until 21 January 1998. Fourteen patients have been hospitalised.

The outbreak which began in December 1997 is due to dengue type 3 (outbreaks in northern Queensland in recent years have been due to dengue type 2). There appears to more than a single focus of infection. Residents have been advised to take action to stop mosquitoes breeding around their homes and to avoid being bitten. Mosquito control teams from the Tropical Public Health Unit and Cairns City Council are spraying in and around homes in the dengue warning area. Other recommendations include the screening of doors and windows to prevent mosquito entry and the use of personal insect repellent.

Surveillance data in *CDI*

The *Communicable Diseases Surveillance* section of *Communicable Diseases Intelligence* (*CDI*) includes reports from a number of national surveillance schemes. These schemes are conducted to monitor the occurrence of communicable diseases in Australia, to detect trends, to highlight needs for further investigation and to implement or manage control measures. This article describes the surveillance schemes which are routinely reported on in *CDI*.

Surveillance has been defined by the World Health Organization as the 'continuing scrutiny of all aspects of the occurrence and spread of disease that are pertinent to effective control', it is characterised by 'methods distinguished by their practicability, uniformity, and frequently by their rapidity, rather than complete accuracy.[1] Although some surveillance schemes aim for complete case ascertainment, some include only a sample of all cases of the conditions under surveillance, and these samples are subject to systematic and other biases.

Results generated from surveillance schemes must be interpreted with caution, particularly when comparing results between schemes, between different geographical areas or jurisdictions and over time. Surveillance data may also differ from data on communicable diseases which may be gathered in other settings.

The major features of the surveillance schemes for which *CDI* publishes regular reports are described below. Other surveillance schemes for which *CDI* publishes occasional reports include the National Mycobacterial Surveillance System (*CDI* 1997;21:261-269), the Australian Mycobacterium Reference Laboratory Network (*CDI* 1997;21:245-249), the Hib Case Surveillance Scheme (*CDI* 1997;21:173-176) and the National *Neisseria* Network (*CDI* 1997;21:189-192 and *CDI* 1997;21:217-221).

National Notifiable Diseases Surveillance System

National compilations of notifiable diseases have been published intermittently in a number of publications since 1917 (see *CDI* 1993;17:226-236). The National Notifiable Diseases Surveillance System (NNDSS) was established in 1990 under the auspices of the Communicable Diseases Network Australia New Zealand (CDNANZ).

The system coordinates the national surveillance of more than 40 communicable diseases or disease groups endorsed by the National Health and Medical Research Council (NHMRC).[2] Under this scheme, notifications are made to the State or Territory health authority under the provisions of the public health legislation in their jurisdiction. Computerised, de-identified unit records of notifications are supplied to the network secretariat at the Department of Health and Family Services for collation, analysis and publication in *CDI.*

Data provided for each notification include a unique record reference number, State or Territory code, disease code, date of onset, date of notification to the relevant health authority, sex, age, Aboriginality, postcode of residence, and the confirmation status of the report (as defined by each State or Territory).

Each fortnight, State and Territory health authorities submit a file of notifications received for the year to date; the data files therefore include notifications for both the current reporting period and updated notifications for all previous reporting periods in the current year.

The data are presented on the *Communicable Diseases - Australia* internet site each fortnight. They are also published in *CDI* every four weeks. Cases reported to State and Territory health authorities for the current reporting period are listed by State or Territory, and totals for Australia are presented for the current period, the year to date, and for the corresponding periods of the previous year. HIV infection and AIDS notifications are not included in this section of *CDI*. Surveillance for these conditions is conducted separately by the National Centre for HIV Epidemiology and Clinical Research and is reported in the HIV and AIDS Surveillance reports (see below).

A commentary on the notification data is included with the tables in each issue and graphs are used to illustrate trends in the data.

The interval from the end of a reporting period to the date of publication of collated data in *CDI* is currently 15 days.

The quality and completeness of data compiled in the National Notifiable Diseases Surveillance System are influenced by various factors. Tables, graphs and commentary must be interpreted with caution, particularly when comparisons are made between States and Territories and with data from previous years. Each State or Territory health authority determines which diseases will be notifiable within its jurisdiction, and which notifications are accepted as satisfying criteria. In some cases these differ from the NHMRC case definitions. In addition, the mechanism of notification varies between States and Territories. Notifications may be required from treating clinicians, diagnostic laboratories or hospitals. In some cases different diseases are notifiable by different mechanisms. The proportion of cases seen by health care providers which are the subject of notification to health authorities is not known with certainty for any disease, and may vary among diseases, between jurisdictions and over time.

HIV and AIDS Surveillance

National surveillance for HIV and AIDS is coordinated by the National Centre in HIV Epidemiology and Clinical Research (NCHECR) within the University of New South Wales, 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, either by the diagnosing laboratory (Australian Capital Territory, New South Wales, Tasmania and Victoria) or by a combination of laboratory and doctor sources (Northern Territory, Queensland, South Australia and 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.

Currently, two tables presenting HIV infection diagnoses, AIDS diagnoses and AIDS deaths are published in each issue of *CDI* when available.

Tabulations of diagnoses of HIV infection and AIDS are based on data available three months after the end of the reporting period, to allow for reporting delay and to incorporate newly available information. More detailed information on diagnoses of HIV infections and AIDS is published quarterly in the *Australian HIV Surveillance Report*, available from the NCHECR. In 1997 the centre produced its first annual report.

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 national network of general practitioners who report on a number of conditions each week. The aim of ASPREN is to provide an indicator of the burden of disease in the primary health care setting and to detect trends in consultation rates.

There are currently about 100 participating general practitioners 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 7,000 and 8,000 consultations are recorded each week.

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

For 1998, 12 conditions are being monitored, all of them related to communicable diseases issues.

These include first attendance for an episode of influenza, rubella, measles, chickenpox, pertussis, Ross River virus infection, and gastroenteritis.

The other recordable conditions are: a reaction to pertussis vaccine, or attendances which result in the initaition of HIV testing (by doctor or patient), or in the immunising of a person with ADT (adult diphtheria and tetanus) or pertussis vaccine.

Data for communicable diseases are published every four weeks in *CDI*. For each of the four reporting weeks reviewed, the number of cases is presented in tabular form together with the rate of reporting per 1,000 consultations. Brief comments on the reports accompany the table.

The case definitions are as follows:

Influenza

(a) Viral culture or serological evidence of influenza virus infection, or

(b) influenza epidemic, plus four of the criteria in (c), or

(c) six of the following:

(i) sudden onset (within 12 hours)

(ii) cough

(iii) rigors or chills

(iv) fever

(v) prostration and weakness

(vi) myalgia, widespread aches and pains

(vii) no significant respiratory physical signs other than redness of nasal mucous membrane and throat

(viii) influenza in close contacts.

Rubella

(a) An acute exanthem with enlarged lymph nodes, most prominently suboccipital and post auricular, with a macular rash on the face, spreading to the trunk and proximal portions of the limbs, or

(b) serological evidence of rubella infection.

Measles

(a) Serological or virological evidence of acute measles, or

(b) two of the following:

(i) prodrome including injected conjunctivae, fever and cough

(ii) white specks on a red base in the mucous membranes of the cheek (Koplik's spots)

(iii) confluent maculopapular eruption spreading over the face and body, or

(c) an atypical exanthem in a partially immune person during an epidemic of measles.

Chickenpox

An acute, generalised viral disease with a sudden onset of slight fever, mild constitutional symptoms and a skin eruption which is maculopapular for a few hours, vesicular for 3 to 4 days, and leaves a granular scab.

Pertussis

(a) Respiratory infection with a characteristic staccato paroxysmal cough ending with a high-pitched inspiratory whoop, or

(b) respiratory infection with persistent cough (3 weeks) in contact with known pertussis, or

(c) demonstration of *Bordetella pertussis*.

Ross River virus infection

A patient who presents with:

(a) joint pain, and

(b) lethargy, and

(c) a history of exposure to mosquitoes.

All three must be present for a diagnosis of Ross River virus infection.

Note: this symptom complex would also apply to conditions resulting from infections with Barmah Forest virus and some other arboviruses.

HIV testing (patient initiated)

Testing for HIV undertaken as a result of a patient request.

Note: Requests made by insurance companies for HIV testing should be excluded.

HIV testing (doctor initiated)

Testing initiated for a medical practitioner determined reason**.**

Note: Requests made by insurance companies for HIV testing should be excluded.

Gastroenteritis

Intestinal disease, presumed or proven to be infective in origin, recorded once only.

ADT

Any consultation at which an Adult Diphtheria and Tetanus (ADT) immunisation is given.

Perussis vaccination

Administration of any pertussis containing vaccine.

Pertussis vaccination reaction

An adverse event reported with the following characteristics:

(a) in children who were vaccinated by the reporting general practitioner (not other GPs or clinics) on or after 1 January 1998;

(b) the occurence of one or more of the following symptoms within 48 hours of the administration of vaccination with any pertussis containing vaccine:

(i) local redness or swelling of any severity

(ii) fever greater than 38.0^{o}C

(iii) crying or screaming

(iv) somnolence that interferes with normal play or feeding

(v) any severe event (as indicated in the current Australian Immunisation Handbook, for example, seizure, hypotonic-hyporesponsive episode, anaphylaxis.

Note: the adverse reaction may be reported in person or by telephone, at the time of the event or at a subsequent visit for a scheduled vaccination.

Surveillance of Serious Adverse Events Following Vaccination

The Serious Adverse Events Following Vaccination Surveillance Scheme is a national surveillance scheme initiated through the National Childhood Immunisation Program. The scheme aims to identify and report in a timely fashion all serious adverse events which follow childhood vaccination. This permits (i) the identification of illnesses of infrequent occurrence that may be associated with vaccination, (ii) the estimation of rates of occurrence of events temporally associated with vaccination, (iii) monitoring for unusually high rates of adverse events, (iv) the provision of information to inform the debate on the risks and benefits of vaccines and (v) the identification of areas that require further research.

A serious adverse event following vaccination is defined as:

(a) The occurrence of one or more of the following conditions within 48 hours of the administration of a vaccine:

(i) persistent screaming (for more than three hours)

(ii) a temperature of 40.5^{o}C or more, unexplained by any other cause

(iii) anaphylaxis

(iv) shock

(v) hypotonic/hyporesponsive episode, or

(b) the occurrence of one or more of the following conditions within 30 days of the administration of a vaccine:

(vi) encephalopathy

(vii) convulsions

(viii) aseptic meningitis

(ix) thrombocytopaenia

(x) acute flaccid paralysis

(xi) death

(xii) other serious event thought to be associated with a vaccination.

Reports on serious adverse events are collected by State and Territory health authorities and forwarded to the Department of Health and Family Services every fortnight. Information collected on each case includes the vaccine(s) temporally associated with the event, possible risk factors in the child's medical history and details about the nature, timing and outcome of the event. Methods of collecting reports vary between States and Territories. Telephone reporting is accepted to minimise health care provider paperwork. States and Territories also report on follow up at 60 days.

Reports of the surveillance scheme are published quarterly. Acceptance of a report does not imply a causal relationship between the administration of the vaccine and the medical outcome, or that the report has been verified as to its accuracy.

Sentinel Chicken Surveillance Programme

The Sentinel Chicken Surveillance Programme is used to provide an early warning of increased flavivirus activity in Australia. The main viruses of concern are Murray Valley encephalitis (MVE) and Kunjin which cause the potentially fatal disease Australian encephalitis in humans. These viruses are enzootic in parts of the north-east Kimberley region of Western Australia and the Northern Territory but are epizootic in other areas of the Kimberley and in north Queensland. MVE virus is also responsible for occasional severe epidemics of Australian encephalitis in eastern Australia. The most recent was in 1974 when there were 13 fatalities and cases were reported from all mainland States. Since then, 48 cases have been reported and all but one of these were from the north of Australia.

Since 1974, a number of sentinel chicken flocks have been established in Australia to provide an early warning of increased MVE virus activity. These programs are supported by individual State health departments. Each State has a contingency plan which will be implemented if one or more chickens in a flock seroconverts to MVE virus.

Currently 26 flocks are maintained in the north of Western Australia, seven in the Northern Territory, nine in New South Wales and ten in Victoria (Figures 1, 2, 3 and 4). The flocks in Western Australia and the Northern Territory are tested all year round but those in New South Wales and

Figure 1. Sentinel chicken flock sites, Western Australia

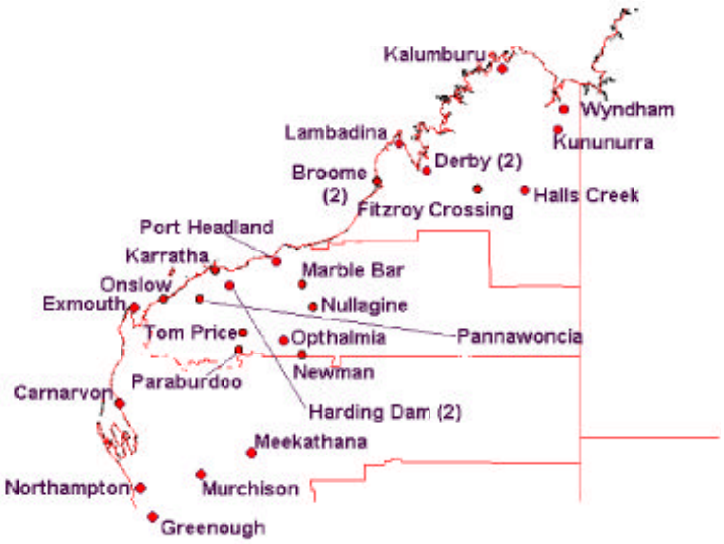


Figure 2. Sentinel chicken flock sites, Victoria

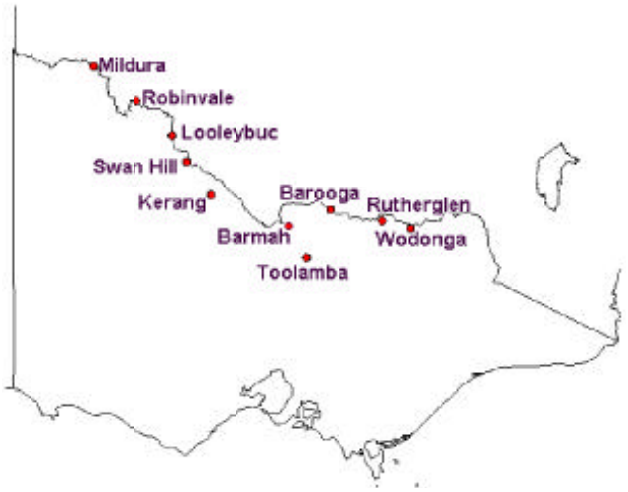


Figure 3. Sentinel chicken flock sites, New South Wales

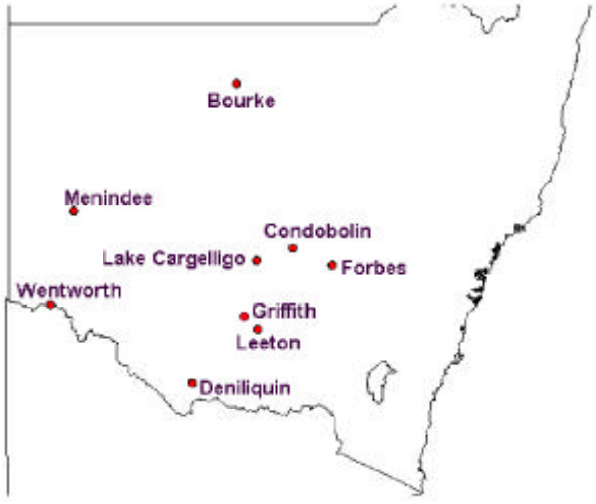
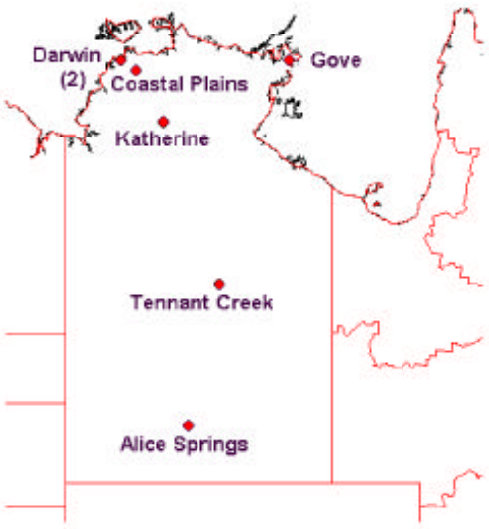


Figure 4. Sentinel chicken flock sites, Northern Territory



Victoria are tested only in the summer months,during the main MVE risk season.

Results are coordinated by the Arbovirus Laboratory in Perth and reported bimonthly.

Gonococcal surveillance

The Australian Gonococcal Surveillance Programme (AGSP) includes ten reference laboratories in all States and Territories and in New Zealand. These laboratories report data on sensitivity to an agreed 'core' group of antimicrobial agents quarterly. The antibiotics which are currently routinely surveyed are the penicillins, ceftriaxone, ciprofloxacin and spectinomycin, all of which are administered as single dose regimens. When in vitro resistance to a recommended agent is demonstrated in 5% or more of isolates, it is usual to reconsider the inclusion of that agent in current treatment schedules. 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 resistance to the tetracyclines. Comparability of data is achieved by means of a standardised system of testing and a program-specific quality assurance process. Reports of the program are published quarterly.

National Influenza Surveillance

Influenza surveillance in Australia is based on several schemes collecting a range of data which can be used to measure influenza activity. From autumn to spring, the results of each of the schemes are published together as National Influenza Surveillance to facilitate a national view of influenza activity.

In 1997, four sentinel general practitioner schemes contributed reports of influenza-like illness: the Australian Sentinel Practice Research Network, Tropical Influenza Surveillance from the Northern Territory, the New South Wales Sentinel General Practice Scheme and the Victorian Sentinel General Practice Scheme. The number of cases of influenza and the total consultations for each week are reported, and a graph depicts the data for the season to date.

National absenteeism surveillance data are provided by Australia Post. Reports are based on the proportion of their employees (approximately 37,000) absent on sick leave for a selected day each week. Absenteeism data for the reporting period is published in each issue.

The *CDI* Virology and Serology Laboratory Reporting Scheme contributes laboratory reports of influenza diagnoses, by week of specimen collection, virus type and method of diagnosis. Graphs of the data for the year to date are presented. The WHO Collaborating Centre for Influenza Reference and Research at the Commonwealth Serum Laboratories, Melbourne provides information on antigenic analysis of isolates received from Australia, New Zealand, other countries of the region and South Africa.

Virology and Serology Laboratory Reporting Scheme (LabVISE)

The Virology and Serology Laboratory Reporting Scheme began operating in 1977. The scheme comprises 21 sentinel laboratories from all States and the Australian Capital Territory. Contributors submit data on the laboratory identification of viruses and other organisms. Laboratories elect to submit data either on computer disk using LabVISE software (written in Epi Info), or on paper forms in the same format. Each record includes mandatory data fields (laboratory, specimen collection date, a patient identifier code, specimen source, the agent detected and the method of diagnosis), and optional fields (specimen code number, sex, date of birth or age, postcode of residence, clinical diagnosis, risk factors and comments).

Reports are collated, analysed and published currently every four weeks. Each report includes two summary tables. The delay between date of specimen collection and date of publication ranges from two weeks to several months. A commentary on the laboratory reports includes the observation of recent trends with accompanying graphical presentation.

Data derived from this scheme must be interpreted with caution. The number and type of reports received is subject to a number of biases. These include the number of participating laboratories which has varied over time. The locations of participating laboratories also create bias, as some jurisdictions are better represented than others. Also changes in diagnostic practices, particularly the introduction of new testing methodologies, may affect laboratory reports. The ability of laboratory tests to distinguish acute from chronic or past infection must also be considered in interpretation of the data.

This is a sentinel scheme hence changes in incidence cannot be determined. However general trends can be observed, for example with respect to seasonality and the age-sex distribution of patients.

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