Change to calendar month publication date

From April 2000 onwards, *Communicable Diseases Intelligence* will be produced each calendar month.

This replaces the previous 4-weekly production schedule, and corresponds to the new schedule presenting surveillance data by calendar month periods.

Supplementary issue of *CDI*

In order to adjust to the new calendar month schedule, an extra March 2000 Supplementary issue is presented.

World TB Day

World TB Day, celebrated 24 March this year, united the global community of people concerned about Tuberculosis.

The theme for 2000, 'Forging new partnerships to stop TB', called for outreach beyond the TB community to include new partners in the fight against TB. For more information, see the NPIN Web Spotlight at http://www.cdcnpin.org/spotlight.htm

Disease activity in Victoria

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Meningococcal infection

There were 4 cases of meningococcal infection in Victoria with onset in February. Two cases were male and the median age was 23 years (range 16 to 57 years). Two cases presented with meningitis and 2 with septicaemia. Three isolates were group C and 1 was group B.

Viral meningitis

Victoria is currently experiencing a widespread outbreak of viral meningitis. Where viral studies have been complete, this has been shown to be predominantly due to the enterovirus ECHO 30. The last such outbreak of echovirus 30 occurred in the summer of 1993-94. The current outbreak appears to have surpassed levels experienced at that time. Enterovirus is not a notifiable disease in Victoria. The Department has issued a public health alert to medical practitioners and hospitals advising them of the outbreak, the nature of the illness, and the importance of treating and notifying suspected cases of bacterial meningitis.

Legionellosis

In Victoria this year, there have been 37 cases notified as at 26 March 2000 compared to 32 for the same period last year. Thirty-four of these were due to *L. pneumophila 1*, one due to *L. pneumophila 4*, one due to *L. longbeachae*, and one due to *L. micdadei*. Three of the 37 cases died as a result of their infection. The Communicable Diseases Section identified three distinct outbreaks; one in the Thomastown area, one in Carlton/Fitzroy, and one in the Central Business District of Melbourne. The Department was unable to identify a definitive source for any of the clusters, although cooling towers in the surrounding areas were tested and disinfected. There has also been some clustering of other cases. It is suspected that the increased use of the rapid urinary antigen test for diagnosis may have assisted in the identification of the clusters and resulted in an increase in notifications.

Department of Human Services Web Site:
http://www.dhs.vic.gov.au/

See what's new in Infectious Diseases in Victoria:
http://www.dhs.vic.gov.au/phd/vidb/index.htm

Editorial comment

Legionellosis

Lp-1 antigens can be detected in the urine of infected patients using a commercially available radioimmunoassay (RIA) or enzyme immunoassay (EIA). This test has several advantages for detecting Lp-1. It is rapid, highly specific for Lp-1 infection and it may remain positive for days or weeks after initiation of antibiotics. It is not an appropriate test for the diagnosis of legionellosis caused by other serogroups of *L. pneumophila* or other legionellae.[1]

Table 1 presents commonly used diagnostic tests for *Legionella* and compares sensitivity, specificity and diagnostic utility. Genetic probes and nucleic acid amplification techniques are promising alternatives to these methods although clinical experience with these techniques is currently limited.[2]

References

1. Chang F-Y, Jacobs SL, Colodny SM, Stout JE, Yu VL. Nosocomial Legionnaires' disease caused by *Legionella pneumophila* serogroup 5: Laboratory and epidemiologic implications. *J Infect Dis* 1996;174:1116-1119.
2. Fiore AE, Butler JC. Detecting nosocomial Legionnaire's disease. *Infect Med* 1998;15:625-630, 633-635.
3. Edelstein PH. Legionnaire's disease. *Clin Infect Dis* 1993;16:741-749.

Table I. Diagnosis of legionnaires' disease[3]

Test	Sensitivity	Specificity	Advantages	Disadvantages
Culture	Varies	100%	Comparison with other clinical and environmental isolates.	Some species harder to culture. Needs specialised culture media. Ability to culture varies among laboratories. Requires sputum or tissue specimen.
Urine antigen (RIA or EIA)	60% to 80% (Lp-1 only)	>99%	Rapid. Detectable even after antibiotics initiated. May remain detectable for days to weeks after onset.	Only detects disease due to Lp-1. RIA requires radioisotope-capable facility.
IFA (4-fold rise in titer)	60% to 80%	95% (Lp-1) Unknown for other species	Retrospective diagnosis possible if acute-phase sera available.	Seroconversion often delayed beyond 4 weeks. Immunosuppressed may not seroconvert. Sensitivity and specificity likely reduced in non-Lp-1 strains. Single specimen elevated titers are nonspecific. Requires convalescent-phase specimen to demonstrate 4-fold rise in titer.
DFA	25% to 75%	95%	Rapid. May remain positive after antibiotics initiated.	Requires specific antisera. Requires experienced laboratory personnel. Polyvalent antisera less specific. Requires sputum or tissue specimen.

DFA = direct fluorescent antibody assay
EIA = enzyme immunoassay
IFA = immunofluorescent antibody assay
Lp-1 = *Legionella pneumophila* serogroup 1
RIA = radioimmunoassay.