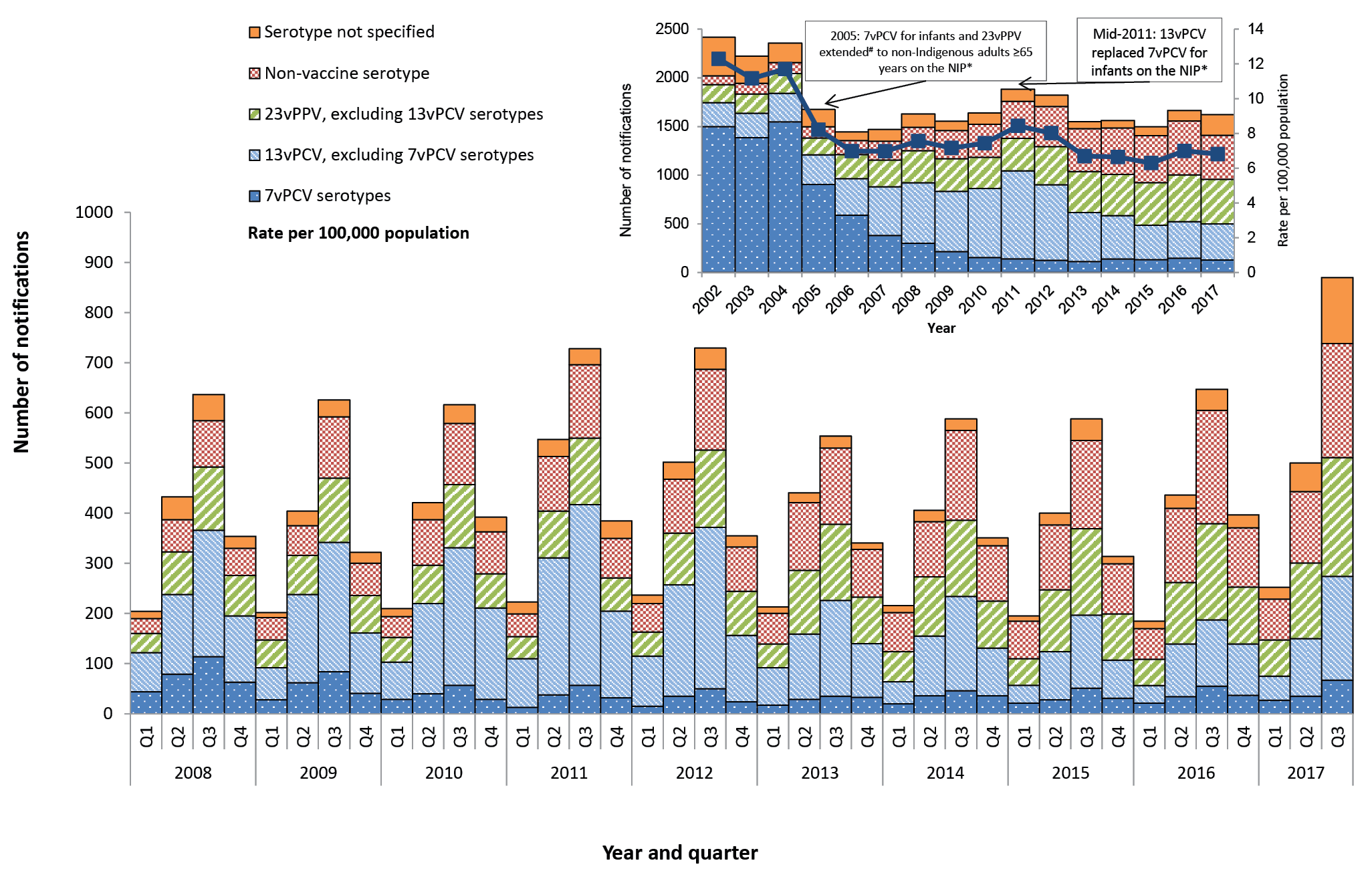
Invasive Pneumococcal Disease Surveillance, 1 July to 30 September 2017[[1]](#footnote-2)

Kate Pennington and the Enhanced Invasive Pneumococcal Disease Surveillance Working Group, for the Communicable Diseases Network Australia

# Summary

The number of notified cases of invasive pneumococcal disease (IPD) in the third quarter of 2017 was greater than the previous quarter and also the third quarter of 2016. Following the July 2011 replacement of the 7-valent pneumococcal conjugate vaccine (7vPCV) in the childhood immunisation program with the 13-valent pneumococcal conjugate vaccine (13vPCV), there was an initial relatively rapid decline in disease due to the additional six serotypes covered by the 13vPCV across all age groups, however in 2017 this decline is no longer evident. Further, over this period the number of cases due to the eleven serotypes additionally covered by the 23-valent pneumococcal polysaccharide vaccine (23vPPV) and also those serotypes not covered by any available vaccine has been increasing steadily across all age groups (Figure 1).

Figure 1: Notifications of invasive pneumococcal disease, Australia, 1 January 2002 to 30 September 2017, by vaccine serotype group, year and quarter



# In 1999, the 23vPPV was funded for all Indigenous Australians aged 50 years and over, as well as younger Indigenous Australian adults with risk factors.

\* NIP - National Immunisation Program.

# Key points

In the third quarter of 2017, there were 870 cases of IPD reported to the National Notifiable Disease Surveillance System (NNDSS). Compared with the number of cases notified in the previous quarter (n=500), this represented a substantial increase in cases (75%), and compared with the same quarter in 2016 (n=647) there was a 34% increase in the number of cases (Table 1). The increase observed in this quarter was consistent with the seasonal increase in cases observed in quarters two and three each year (Figure 1), with IPD notification activity during this period tending to correlate with the winter influenza seasons. The unexpectedly higher levels of IPD observed over the past quarter may potentially have been influenced by the increased seasonal influenza activity levels that have also been observed over this period. In the third quarter of 2017, the most common pneumococcal serotypes causing IPD were 3 (14.6%), 19A (7.5%) and 9N (6.9%) (Table 2).

Table 1: Notified cases of invasive pneumococcal disease, Australia, 1 July to 30 September 2017, by Indigenous status, serotype completeness and state or territory

| Indigenous status | ACT | NSW | NT | Qld | SA | Tas | Vic | WA | Total 3rd qtr 2017 | Total 2nd qtr 2017 | Total 3rd qtr 2016 | Year to date 2017 |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Indigenous | 0 | 15 | 26 | 25 | 8 | 1 | 0 | 22 | 97 | 41 | 75 | 168 |
| Non-Indigenous | 5 | 237 | 6 | 114 | 73 | 19 | 137 | 64 | 655 | 401 | 521 | 1245 |
| Not stated / Unknown | 0 | 46 | 0 | 0 | 1 | 1 | 70 | 0 | 118 | 58 | 51 | 209 |
| Total | 5 | 298 | 32 | 139 | 82 | 21 | 207 | 86 | 870 | 500 | 647 | 1,622 |
| Indigenous status completeness\* (%) | 100 | 85 | 100 | 100 | 99 | 95 | 66 | 100 | 86 | 88 | 92 | 87 |
| Indigenous status completeness in targeted groups \*† (%) | 100 | 90 | 100 | 100 | 98 | 94 | 84 | 100 | 92 | 94 | 98 | 93 |
| Serotype completeness ǂ (%) | 100 | 76 | 94 | 96 | 62 | 95 | 96 | 92 | 85 | 91 | 96 | 88 |

\* Indigenous status completeness is defined as the reporting of a known Indigenous status, excluding the reporting of not stated or unknown Indigenous status.

† Targeted groups for follow-up by almost all jurisdictions and public health units are cases aged less than 5 years and 50 years and over.

‡ Serotype completeness is the proportion of all cases of invasive pneumococcal disease that were reported with a serotype or reported as non-typable. Incomplete serotype data can occur in cases when (i) no isolate was available as diagnosis was by polymerase chain reaction and no molecular typing was attempted or was not possible due to insufficient genetic material; (ii) the isolate was not referred to the reference laboratory or was not viable; (iii) typing was pending at the time of reporting, or no serotype was reported by the notifying jurisdiction to the National Notifiable Diseases Surveillance System.

Table 2: Distribution of serotypes causing invasive pneumococcal disease in notified cases, Australia, 1 July to 30 September 2017, by age group

| Serotype | Vaccine type | Age groups | | |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Under 5 years | 5–64 years | Over 65 years | Serotype total |
| 3 | 13vPCV non-7vPCV | 11 | 55 | 61 | 127 |
| 19A | 13vPCV non-7vPCV | 14 | 28 | 23 | 65 |
| 9N | 23vPPV non-13vPCV | 1 | 35 | 24 | 60 |
| 22F | 23vPPV non-13vPCV | 1 | 31 | 22 | 54 |
| 19F | 7vPCV | 4 | 20 | 21 | 45 |
| 23A | Non-vaccine type | 1 | 7 | 25 | 33 |
| 8 | 23vPPV non-13vPCV | 4 | 19 | 5 | 28 |
| 6C | Non-vaccine type | 1 | 10 | 17 | 28 |
| 11A | 23vPPV non-13vPCV | 3 | 15 | 9 | 27 |
| 33F | 23vPPV non-13vPCV | 2 | 13 | 10 | 25 |
| 15A | Non-vaccine type | 2 | 6 | 15 | 23 |
| 16F | Non-vaccine type | - | 8 | 12 | 20 |
| 35B | Non-vaccine type | 2 | 6 | 11 | 19 |
| 23B | Non-vaccine type | 5 | 5 | 8 | 18 |
| 7F | 13vPCV non-7vPCV | - | 14 | - | 14 |
| 18A | Non-vaccine type | - | 11 | 1 | 12 |
| 31 | Non-vaccine type | - | 6 | 5 | 11 |
| 38 | Non-vaccine type | 1 | 4 | 6 | 11 |
| 12F | 23vPPV non-13vPCV | - | 10 | 1 | 11 |
| 15C | Non-vaccine type | 2 | 4 | 4 | 10 |
| 15B | 23vPPV non-13vPCV | 2 | 5 | 2 | 9 |
| 17F | 23vPPV non-13vPCV | - | 5 | 4 | 9 |
| 14 | 7vPCV | - | 5 | 2 | 7 |
| 20 | 23vPPV non-13vPCV | - | 2 | 5 | 7 |
| 10A | 23vPPV non-13vPCV | 2 | 3 | 2 | 7 |
| 24 | Non-vaccine type | 1 | 3 | 2 | 6 |
| 35F | Non-vaccine type | - | 3 | 3 | 6 |
| 13 | Non-vaccine type | - | 4 | 1 | 5 |
| 34 | Non-vaccine type | 1 | 3 | 1 | 5 |
| Other | - | 3 | 22 | 11 | 36 |
| Unknown | - | 34 | 60 | 38 | 132 |
| Total |  | 97 | 422 | 351 | 870 |

\* Serotypes that only occur in less than 5 cases per quarter are grouped as ‘Other’ and include ‘non-typable’ isolates this quarter.

† ‘Serotype unknown’ includes those serotypes reported as ‘no isolate’, ‘not referred’, ‘not viable’, ‘typing pending’ and ‘untyped’.

Table 3: Notified cases of invasive pneumococcal disease, Australia, 1 July to 30 September 2017, by Indigenous status and age group

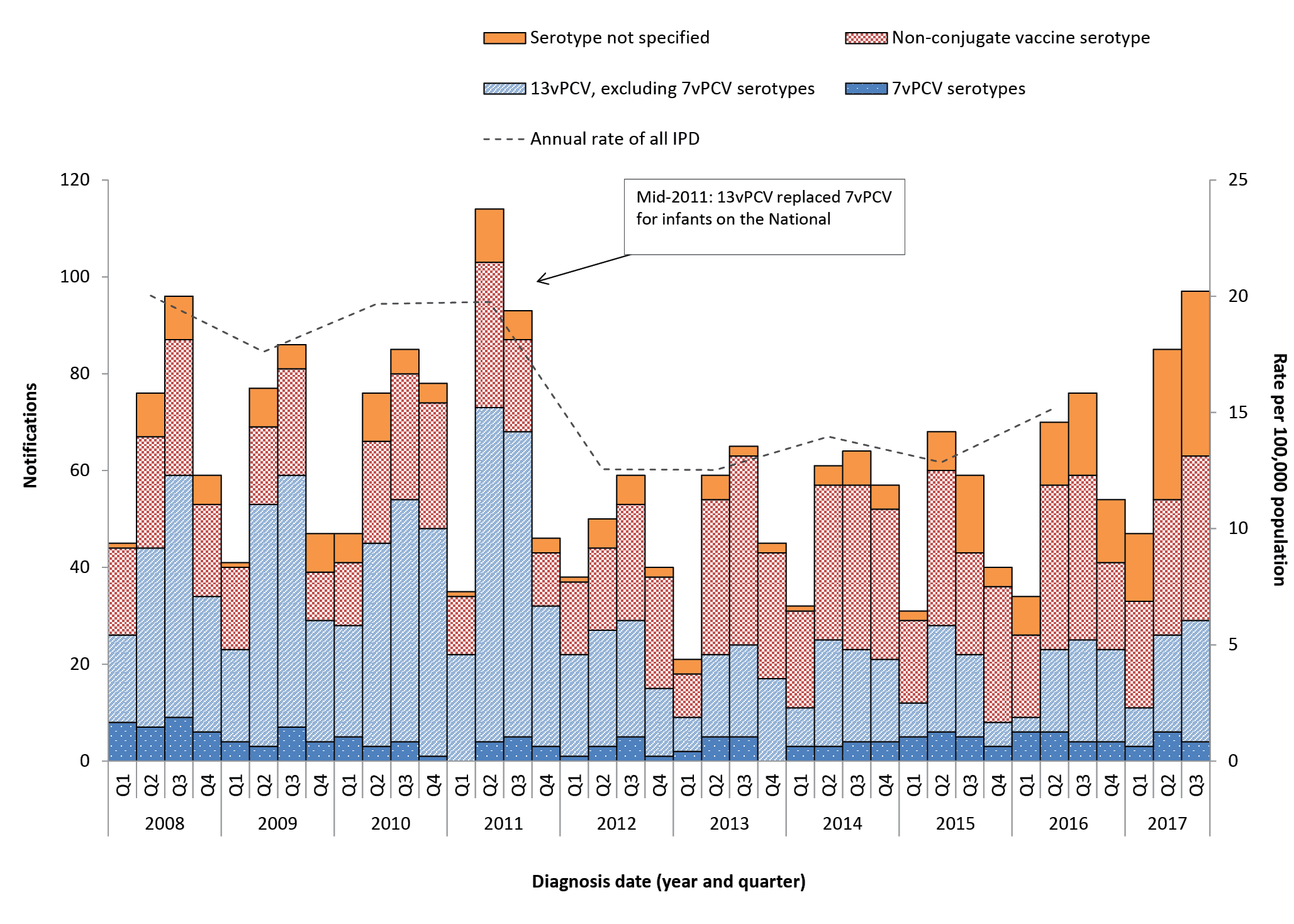
| Age group | Indigenous status | | | Total |
| --- | --- | --- | --- | --- |
| Indigenous | Non-Indigenous | Not reported\* |
| 00–04 | 4 | 91 | 2 | 97 |
| 05–09 | 2 | 19 | 5 | 26 |
| 10–14 | 5 | 3 | 6 | 14 |
| 15–19 | 5 | 5 | 5 | 15 |
| 20–24 | 4 | 6 | 4 | 14 |
| 25–29 | 8 | 5 | 3 | 16 |
| 30–34 | 9 | 12 | 8 | 29 |
| 35–39 | 8 | 18 | 14 | 40 |
| 40–44 | 9 | 14 | 11 | 34 |
| 45–49 | 10 | 20 | 11 | 41 |
| 50–54 | 8 | 39 | 6 | 53 |
| 55–59 | 2 | 36 | 5 | 43 |
| 60–64 | 11 | 74 | 12 | 97 |
| 65–69 | 5 | 67 | 10 | 82 |
| 70–74 | 3 | 64 | 3 | 70 |
| 75–79 | 2 | 48 | 4 | 54 |
| 80–84 | 0 | 58 | 6 | 64 |
| 85+ | 2 | 76 | 3 | 81 |
| **Total** | **97** | **655** | **118** | **870** |

\* Not reported is defined as not stated, blank or unknown Indigenous status.

Among non-Indigenous Australians[[2]](#footnote-3) this quarter, the number of notified cases continued to be highest in children aged less than 5 years and older adult age groups, especially those aged 60 years or older (Table 3). Among Indigenous Australians, notifications tended to be highest among adults aged 25 to 64 years. The proportion of cases reported as Indigenous Australians this quarter (11%; 97/870) was higher compared with the proportion observed in the previous quarter (8%; 41/500), and similar compared to the proportion reported in the third quarter of 2016 (12%; 75/647) (Table 1).

In children aged less than 5 years, there were 97 cases of IPD reported, representing 11% (97/870) of all cases reported in this quarter. The proportion of cases notified in this age group was lower in this reporting period when compared with the previous quarter (17%; 85/500), and similar compared to the proportion reported in the third quarter of 2016 (12%; 76/647). Of those cases aged less than 5 years with a known serotype reported this quarter, 46% (29/63) were due to a serotype included in the 13vPCV, compared with 48% (26/54) of cases in the previous quarter and 42% (25/59) in the third quarter of 2016 (Figure 2). Of the 29 cases with 13vPCV serotypes in the third quarter of 2017, 20 cases were reported in fully vaccinated children aged less than 5 years and considered to be 13vPCV failures. These 13vPCV failures were due to serotypes 19A (n=12) and 3 (n=8) (Table 4). During this quarter the main serotypes affecting children aged less than 5 years were 19A (22%; 14/63), followed by 3 (17%; 11/63) (Table 2). Both of these serotypes are included in the 13vPCV.

Figure 2: Notifications and annual rates\* of invasive pneumococcal disease in children aged less than 5 years, Australia, 1 January 2008 to 30 September 2017, by vaccine serotype group



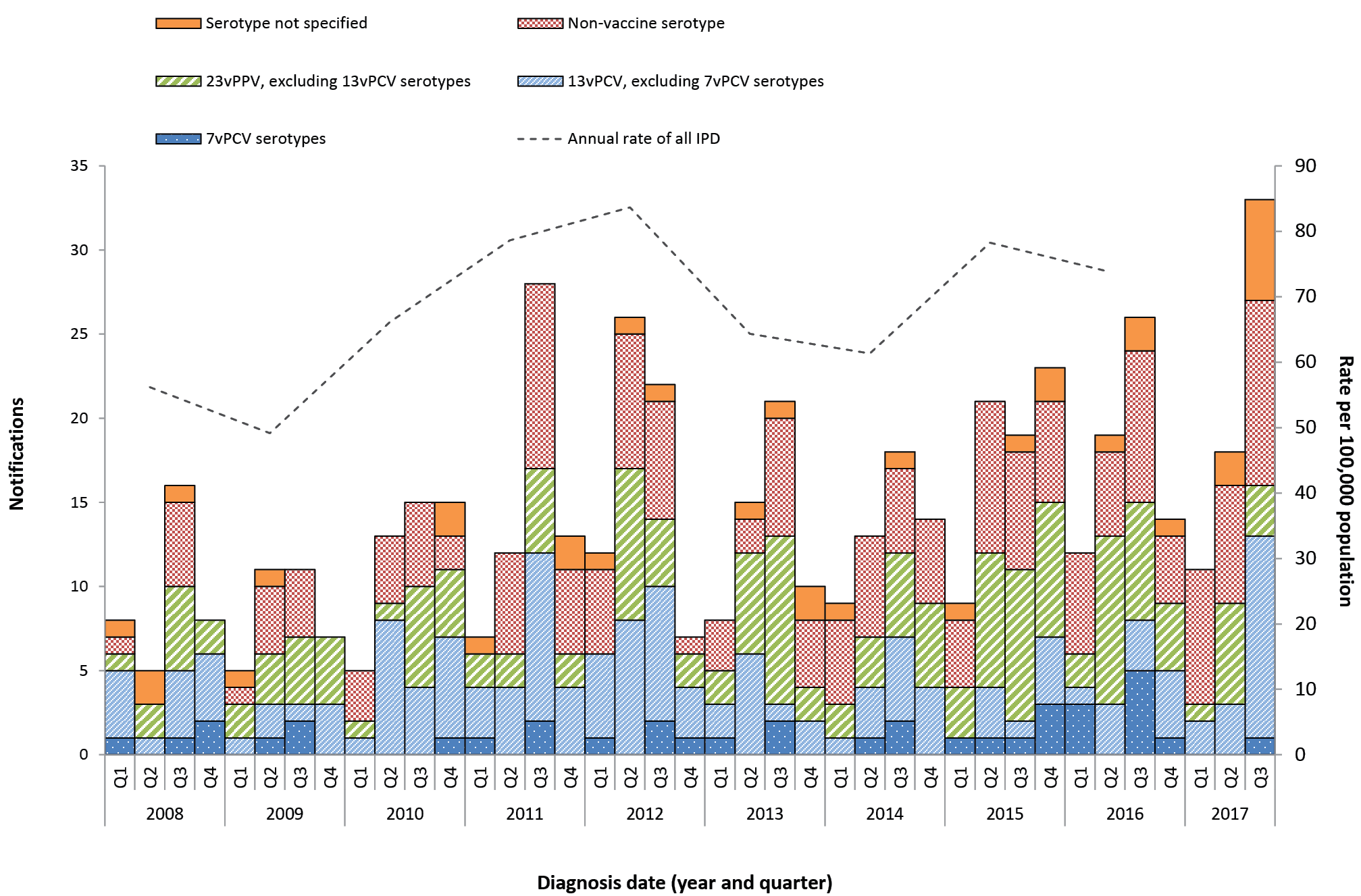
\* Annual rates are shown on quarter 2, excluding 2017.

Table 4: Characteristics of 13vPCV failures in children aged less than 5 years, Australia, 1 July to 30 September 2017

| Age | Indigenous status | Serotype | Clinical category | Risk factor(s) |
| --- | --- | --- | --- | --- |
| 11 months | Non-Indigenous | 19A | Septic arthritis | Childcare attendee |
| 1 year | Non-Indigenous | 19A | Other sterile site | No data available |
| 1 year | Non-Indigenous | 19A | Other sterile site | Premature (<37 weeks gestation) |
| 1 year | Non-Indigenous | 19A | Bacteraemia | No data available |
| 1 year | Non-Indigenous | 3 | Pneumonia and other (pleural effusion) | Unknown |
| 1 year | Non-Indigenous | 19A | Bacteraemia | No data available |
| 1 year | Non-Indigenous | 19A | Other sterile site | Childcare attendee |
| 1 year | Non-Indigenous | 19A | Pneumonia | No data available |
| 2 years | Non-Indigenous | 3 | Other sterile site | Other |
| 2 years | Non-Indigenous | 3 | Pneumonia and other (pleural effusion) | No data available |
| 2 years | Non-Indigenous | 19A | Pneumonia | Childcare attendee |
| 2 years | Non-Indigenous | 19A | Other sterile site | Childcare attendee |
| 2 years | Non-Indigenous | 19A | Pneumonia | Childcare attendee |
| 2 years | Non-Indigenous | 3 | Pneumonia | No data available |
| 2 years | Non-Indigenous | 19A | Pleural effusion | No risk factor identified |
| 2 years | Non-Indigenous | 3 | Pneumonia and other (pleural effusion) | No data available |
| 3 years | Indigenous | 3 | Pneumonia | No risk factor identified |
| 3 years | Non-Indigenous | 19A | Pneumonia and other (pleural empyema) | Other |
| 3 years | Non-Indigenous | 3 | Pneumonia and other (pleural effusion) | Childcare attendee |
| 3 years | Non-Indigenous | 3 | Pneumonia | Congenital or chromosomal abnormality |

Among Indigenous Australians aged 50 years and over, there were 33 cases of IPD reported this quarter. Of those cases with a reported serotype (n=27), 16 (59%) were due to a serotype included in the 23vPPV, with half of these cases due to serotype 3 (n=8) (Figure 3). The number of notified cases of IPD in this population group were higher than the number of cases reported in both the previous quarter (n=18) and also the number reported in the third quarter of 2016 (n=26).

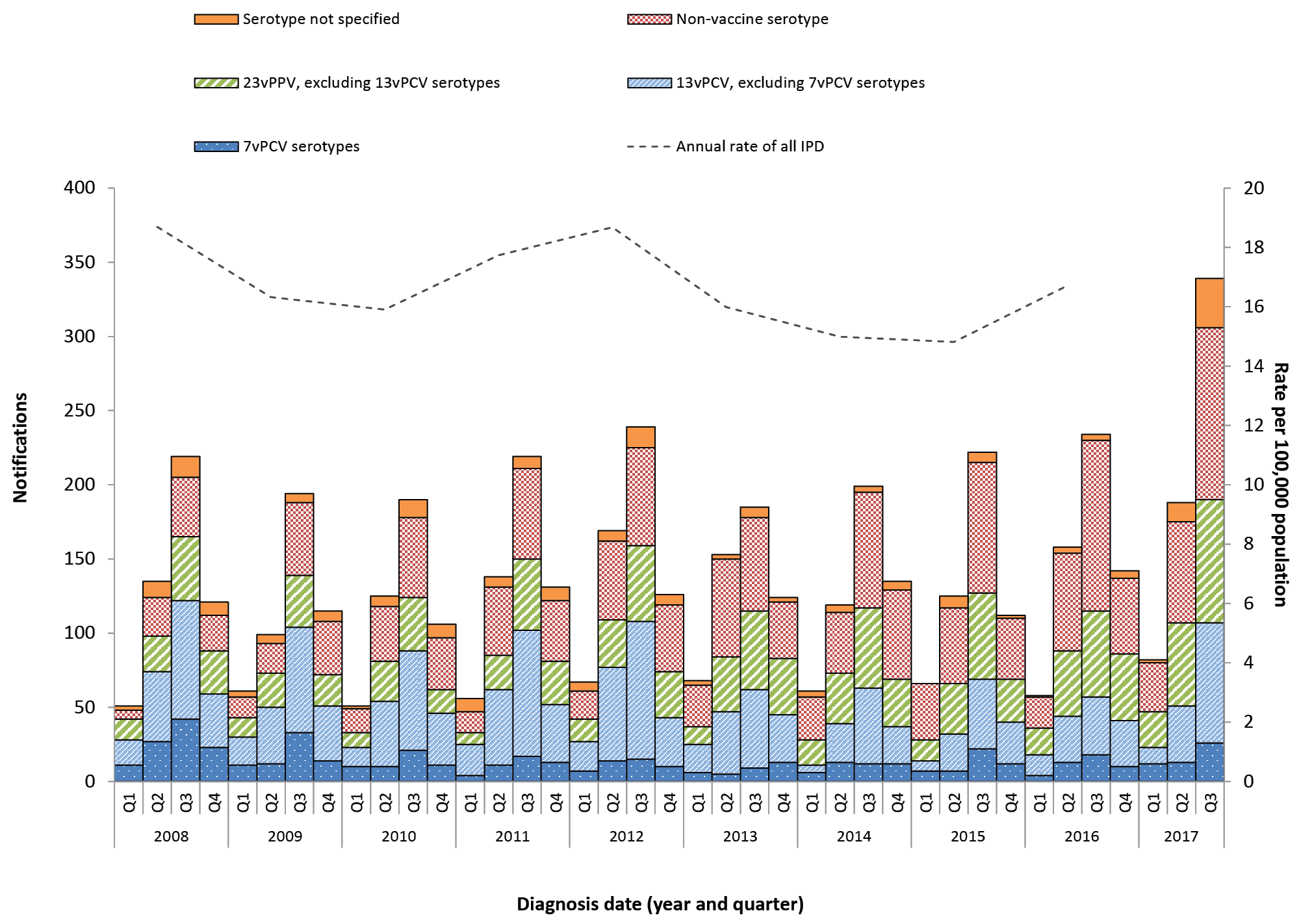
Figure 3: Notifications and annual rates\* of all invasive pneumococcal disease in Indigenous Australians aged 50 years or over, Australia, 1 January 2008 to 30 September 2017, by vaccine serotype group



\* Annual rates are shown on quarter 2, excluding 2017.

Among non-Indigenous Australians aged 65 years and over there were 339 cases of IPD reported this quarter. The number of notified cases of IPD in this population group were 80% higher compared to the number of cases reported in the previous quarter (n=188) and 45% higher than the number reported in the third quarter of 2016 (n=234). Of those cases with a reported serotype (n=306), almost two-thirds (62%; 190/306) were due to a serotype included in the 23vPPV (Figure 4), which was similar to the proportion in the previous quarter (62%; 107/175). For this quarter, serotype 3 (n=59) was the most common serotype for this population group followed by 23A (n=25), 9N (n=23), 19A (n=22), 22F (n=22) and 19F (n=22). All of these serotypes, except 23A, are included in the 23vPPV.

Figure 4: Notifications and annual rates\* of all invasive pneumococcal disease in non-indigenous Australians# aged 65 years or over, Australia, 1 January 2008 to 30 September 2017, by vaccine serotype group



\* Annual rates are shown on quarter 2, excluding 2017.

# Non-Indigenous Australians includes cases reported as non-Indigenous, not stated, blank or unknown.

During this quarter there were 65 deaths attributed to a variety of IPD serotypes, with serotypes 9N (n=9), 3 (n=8) and 19F (n=6) being the most common. Almost all of the reported deaths (92%; n=60) occurred in non-Indigenous Australians. The median age of those cases reported to have died this quarter was 67 years (range 0 to 102 years).

# Notes

The data in this report are provisional and subject to change as laboratory results and additional case information become available. More detailed data analysis of IPD in Australia and surveillance methodology are described in the IPD annual report series published in Communicable Diseases Intelligence.

In Australia, pneumococcal vaccination is recommended as part of routine immunisation for children, individuals with specific underlying conditions associated with increased risk of IPD and older Australians. More information on the scheduling of the pneumococcal vaccination can be found on the Immunise Australia Program website (www.immunise.health.gov.au).

In this report, a ‘vaccine failure’ is reported when a child aged less than 5 years is diagnosed with IPD due to a serotype found in the 13vPCV and they have received 3 primary scheduled doses of 13vPCV at least 2 weeks prior to disease onset with at least 28 days between doses of vaccine.

There are 3 pneumococcal vaccines available in Australia, each targeting multiple serotypes (Table 5). Note that in this report serotype analysis is generally grouped according to vaccine composition.

Table 5: Streptococcus pneumoniae serotypes targeted by pneumococcal vaccines

| Serotypes | 7-valent pneumococcal conjugate vaccine (7vPCV) | 10-valent pneumococcal conjugate vaccine (10vPCV) | 13-valent pneumococcal conjugate vaccine (13vPCV) | 23-valent pneumococcal polysaccharide vaccine (23vPPV) |
| --- | --- | --- | --- | --- |
| 1 |  | ✓ | ✓ | ✓ |
| 2 |  |  |  | ✓ |
| 3 |  |  | ✓ | ✓ |
| 4 | ✓ | ✓ | ✓ | ✓ |
| 5 |  | ✓ | ✓ | ✓ |
| 6A |  |  | ✓ |  |
| 6B | ✓ | ✓ | ✓ | ✓ |
| 7F |  | ✓ | ✓ | ✓ |
| 8 |  |  |  | ✓ |
| 9N |  |  |  | ✓ |
| 9V | ✓ | ✓ | ✓ | ✓ |
| 10A |  |  |  | ✓ |
| 11A |  |  |  | ✓ |
| 12F |  |  |  | ✓ |
| 14 | ✓ | ✓ | ✓ | ✓ |
| 15B |  |  |  | ✓ |
| 17F |  |  |  | ✓ |
| 18C | ✓ | ✓ | ✓ | ✓ |
| 19A |  |  | ✓ | ✓ |
| 19F | ✓ | ✓ | ✓ | ✓ |
| 20 |  |  |  | ✓ |
| 22F |  |  |  | ✓ |
| 23F | ✓ | ✓ | ✓ | ✓ |
| 33F |  |  |  | ✓ |

Follow-up of all notified cases of IPD is undertaken in all states and territories except New South Wales and Victoria who conduct targeted follow-up of notified cases aged under 5 years, and 50 years or over for enhanced data. Follow-up of notified cases of IPD in Queensland is undertaken in all areas except Metro South and Gold Coast Public Health Units who conduct targeted follow-up of notified cases for those aged under 5 years only. However, in these areas where targeted case follow-up is undertaken, some enhanced data may also be available outside these targeted age groups.

# Acknowledgements

Report prepared with the assistance of Mr Mark Trungove and Ms Rachael Corvisy on behalf of the Enhanced Invasive Pneumococcal Disease Surveillance Working Group.

Enhanced Invasive Pneumococcal Disease Surveillance Working Group contributors to this report include (in alphabetical order): Frank Beard (NCIRS), Heather Cook (NT and secretariat), Lucinda Franklin (Vic.), Carolien Giele (WA), Robin Gilmour (NSW), Michelle Harlock (Tas.), Ben Howden (Microbiological Diagnostic Unit, University of Melbourne), Sanjay Jayasinghe (NCIRS), Vicki Krause (Chair), Shahin Oftadeh (Centre for Infectious Diseases and Microbiology Laboratory Services, NSW Health Pathology), Sue Reid (ACT), Vitali Sintchenko (Centre for Infectious Diseases and Microbiology – Public Health, Westmead Hospital), Helen Smith (Queensland Health Forensic and Scientific Services), Janet Strachan (Vic.), Hannah Vogt (SA), Angela Wakefield (Qld).

# Corresponding author

Kate Pennington  
Communicable Disease Epidemiology and Surveillance Section Office of Health Protection  
Australian Government Department of Health  
GPO Box 9484, MDP 14, Canberra, ACT 2601  
Telephone: +61 2 6289 2725  
Facsimile: +61 2 6289 1070  
Email: cdess@health.gov.au

**Communicable Diseases Intelligence**

ISSN: 2209-6051 Online

**Communicable Diseases Intelligence (CDI) is a peer-reviewed scientific journal published by the Office of Health Protection, Department of Health. The journal aims to disseminate information on the epidemiology, surveillance, prevention and control of communicable diseases of relevance to Australia.**

**Editor:** Cindy Toms

**Deputy Editor:** Simon Petrie

**Design and Production:** Kasra Yousefi

**Editorial Advisory Board:** David Durrheim, Mark Ferson, John Kaldor, Martyn Kirk and Linda Selvey

**Website**: <http://www.health.gov.au/cdi>

**Contacts**Communicable Diseases Intelligence is produced by:   
Health Protection Policy Branch, Office of Health Protection, Australian Government Department of Health  
GPO Box 9848, (MDP 6) CANBERRA ACT 2601

**Email:** [cdi.editor@health.gov.au](mailto:cdi.editor@health.gov.au)

**Submit an Article**You are invited to submit your next communicable disease related article to the Communicable Diseases Intelligence (CDI) for consideration. More information regarding CDI can be found at: <http://health.gov.au/cdi>.

Further enquiries should be directed to: [cdi.editor@health.gov.au](mailto:cdi.editor@health.gov.au).

This journal is indexed by Index Medicus and Medline.

Creative Commons Licence - Attribution-NonCommercial-NoDerivatives CC BY-NC-ND

© 2019 Commonwealth of Australia as represented by the Department of Health

This publication is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International Licence from <https://creativecommons.org/licenses/by-nc-nd/4.0/legalcode> (Licence). You must read and understand the Licence before using any material from this publication.

**Restrictions**The Licence does not cover, and there is no permission given for, use of any of the following material found in this publication (if any):

* the Commonwealth Coat of Arms (by way of information, the terms under which the Coat of Arms may be used can be found at [www.itsanhonour.gov.au](http://www.itsanhonour.gov.au/));
* any logos (including the Department of Health’s logo) and trademarks;
* any photographs and images;
* any signatures; and
* any material belonging to third parties.

**Disclaimer**Opinions expressed in Communicable Diseases Intelligence are those of the authors and not necessarily those of the Australian Government Department of Health or the Communicable Diseases Network Australia. Data may be subject to revision.

**Enquiries**Enquiries regarding any other use of this publication should be addressed to the Communication Branch, Department of Health, GPO Box 9848, Canberra ACT 2601, or via e-mail to: [copyright@health.gov.au](mailto:copyright@health.gov.au)

**Communicable Diseases Network Australia**Communicable Diseases Intelligence contributes to the work of the Communicable Diseases Network Australia.  
<http://www.health.gov.au/cdna>

1. Based on data extracted from the National Notifiable Diseases Surveillance System (NNDSS) on 2 November 2017. Due to the dynamic nature of the NNDSS, data on this extract is subject to retrospective revision and may vary from data reported in published NNDSS reports and reports of notification data by states and territories. [↑](#footnote-ref-2)
2. Non-Indigenous Australians includes cases reported with an Indigenous status of non-Indigenous, not stated, blank or unknown. [↑](#footnote-ref-3)