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In our continuing series of articles on public health surveillance we consider the role and impact of contact tracing on the control of sexually transmitted disease. Historically, punitive measures were enforced to slow the spread of sexually transmitted disease, the application of contact tracing is more recent.

## **CONTACT TRACING**

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### **Introduction**

The aim of a sexually transmitted diseases (STD) control program is to reduce the impact of an STD in the community by:

- reducing the incidence of disease
- reducing the duration of infection
- reducing the complications or anxiety associated with infection
- decreasing the net costs of managing individual cases.

Contact tracing forms part of a comprehensive STD control program that includes the surveillance of disease trends, and the provision of quality clinical and psychosocial services, screening of populations at risk and public education. In determining which STD is selected for contact tracing, priority should be granted to those with a high risk of disease transmission, a high morbidity and those likely to have asymptomatic infection.

Contact tracing (partner notification) is the process of contacting the sexual partners of an individual with an STD, to advise them that they may have been exposed to infection and to encourage them to attend for screening and treatment. This process endeavours to reduce the burden of disease in the population by shortening the duration of infection and reducing the transmission of disease (hence reducing disease incidence). This reduction should also reduce the morbidity of disease and infection, and therefore be of benefit to both the individual and the community.

### **History**

Historically, contact tracing emerged in Britain as part of the Contagious Diseases Acts of 1864 and 1866, in response to an increasing incidence of venereal disease amongst the military. Although strongly supported by the upper classes, some groups vehemently opposed the legislation, considering it to be coercive and discriminatory. Prostitutes fared poorly, being forced to endure compulsory examination and hospitalisation for up to six months. Campaigning by the abolitionists resulted in changes in administration which contributed to the repeal of the Acts in 1886. Contact tracing was not recognised as important in the control of STDs in industrialised society until World War II, when epidemic increases in gonorrhoea and syphilis stimulated the need for urgent public health measures.

In the United States (USA) vigorous public health efforts, initiated by Thomas Parran, led to the development of a strong centralised National Venereal Disease Act in 1938. Treatment centres advocating screening, case-finding, immediate treatment and contact tracing were rapidly established. In Britain, a decentralised STD control program emerged in 1942, centred around the use of STD clinics where an emphasis was placed on specialised staff employed for the tracing of sexual partners. By the late 1950s however, traditional public health measures had declined in most western countries in the mistaken belief that syphilis would soon be eliminated with penicillin.

In Australia, contact tracing and STD services provision was given low priority compared to Britain and the USA. Inner city clinics were grim, understaffed and depended on threats to force individuals to attend for treatment. However, an increase in venereal disease in 1960, coupled with growing international concern about the sensitivity of many strains of gonorrhoea to penicillin prompted the NH&MRC to recommend measures to strengthen methods of STD control. The importance of contact tracing was recognised when the first contact tracer was employed at the new Division of Epidemiology in Sydney in 1968, where the STD clinic was located.

## **Current developments in the control of STDs**

It is currently thought that a small subgroup of individuals with infection are responsible for a disproportionate amount of STDs in the community. This 'core-group' of individuals has the potential to spread or maintain STD endemicity and epidemics through a multiplicity of factors such as variations in duration of infectivity, high rates of sex partner acquisition and mixing patterns with subgroups in the community. Presumably if core-group members are kept free of disease then STDs will be reduced or gradually disappear. The evolution of the 'core-group' concept has profound implications for the control of STDs.

In any particular environment the public health value of contact tracing must be assessed using cost-effectiveness and cost-benefit considerations by comparison with other available control strategies. For example, strategies such as provision of specialised clinical services, community health education, mass treatment and screening (passive case-finding activities).

Contact tracing is an expensive method of finding individual cases. It is most advantageous in low prevalence situations, particularly where a disease is recently introduced to a community. With increasing prevalence, screening becomes more efficient for detecting new cases and in areas of high prevalence of disease mass treatment may be indicated. Epidemiological treatment may be considered a form of selective mass treatment where individuals are treated urgently before the test results are known, if they have a particularly high risk of infection.

## Objectives of contact tracing

The objectives of contact tracing are the same as those of STD control. Decisions to undertake contact tracing must take into account the theory of STD transmission in communities. This includes the need to:

- interrupt the transmission of disease
- prevent complications
- encourage sustained behaviour change.

This can be achieved by:

- reducing the rates of new sex partner acquisition
- reducing the susceptibility of exposed individuals
- reducing the duration of infectivity of infected individuals.

## Approaches to contact tracing

Partner notification can be performed in several ways.

- *Patient referral*: where the index person is responsible for notifying partners and bringing them to treatment.
- *Health-provider referral*: the health care provider obtains identifying information on partners and is responsible for notification.
- *A combined approach*: the index person supplies information on all partners and agrees to notify selected partners. Failure to refer partners initiates intervention by the health worker.

Patient referral is inexpensive and acceptable but non compliance can be a problem. High prevalence populations such as the core group setting, which represent a proportion of persons attending the STD clinic, are more likely to benefit from provider referral. In such settings, contact tracing will result in the early detection and treatment of infection and the prevention of further spread of serious disease. The approach used will depend on the current resources.

## Ethical considerations

Public health services have a responsibility to protect and restore the health of all people. As the spread of some STDs may have serious and far reaching consequences it is the ethical duty of health practitioners to report selected STDs to the appropriate authority. In South Australia this is a legal requirement under section 30, PEH Act 1987. However, contact tracing is not dependent on formal notification to a public health authority. The health care worker making the diagnosis should consider contact tracing if they have the time and skills. In the South Australian STD notification system a doctor may refer the client to STD Services, this is preferable as STD Services have staff skilled in contact tracing. The centralisation of contact tracing enables identification of patterns and networks of transmission that may not be obvious in a decentralised system. The individual right to privacy is protected by not disclosing identifying information about the source to the contacts.

## **Confidentiality**

To ensure patient participation in contact tracing activities, confidentiality must be maintained by all health care providers involved with the case.

## **Data collection**

At Clinic 275 contract tracing is performed for the following infections:

- HIV
- Hepatitis B
- Hepatitis C
- Chlamydia
- Gonorrhoea
- Syphilis

Data are collected to identify important factors in STD transmission, to evaluate the yield (proportion of cases generated) for different categories of patients, to determine appropriate interview periods and to support cost-benefit analysis. Information is collected on the index patient and each nominated partner. These data should include socio-demographic characteristics such as occupation, sex, race, places of sociosexual aggregation and physical characteristics. Information on sexual orientation and practices, number and kind of partners, reproductive status, co-morbidity and dates of exposure are also relevant.

The use of standardised casenotes at Clinic 275 has made it possible to collect and compare information on all cases of disease and complements contact tracing information. These data help to define epidemiological patterns of disease and are an important means of identifying the spread of infection within the community.

## **Evaluation**

At Clinic 275 data are collected and analysed on all cases diagnosed. The range of contact tracing indices include:

- number of index patients interviewed
- number of partners sought, found and counselled
- number of new infections identified and treated as a result of contact tracing
- mode of partner referral.

The above indices are useful for analysing the efficiency of the contact tracing episode.

Monitoring of partner information therefore helps to advance STD control objectives by identifying the impact of active intervention strategies and the current epidemiological trends associated with sexually transmitted disease.

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# HIV INFECTION IN SOUTH AUSTRALIA

## HIV Infection 1985 - 31/12/97

In South Australia 683 individuals have been diagnosed with HIV infection, 630 (92%) males and 53 (8%) females. Of the males, 482 (76%) reported male to male sexual contact, 55 (9%) reported injecting drug use and 27 (4%) reported both risk factors. Injecting drug use was reported by 22 (42%) females diagnosed with HIV infection and 24 (45%) reported heterosexual transmission.

## HIV Infection 01/10/97 - 31/12/97

Nine males and one female were diagnosed with HIV infection in the fourth quarter of this year. Of the nine males, seven identified male to male sexual contact as their risk factor (Table 1.1).

### Incident Cases

Between 01/01/97 and 31/12/97 eight of the ten males who had acquired their infection in the preceding 12 months reported male to male sexual contact as their risk factor (Table 1.2).

## Laboratory Screening For HIV Infection 01/10/97 - 31/12/97

During the fourth quarter of 1997, 18585 screening tests were performed; 9011 on males and 9276 on females, and 298 tests on individuals whose sex was unknown (Table 1.3).

**Table 1.1 HIV infection detected in South Australia between 01/10/97 - 31/12/97 and year to date. Exposure category by sex.**

Exposure Category	4th Quarter 01/10/97 - 31/12/97		Year to date 01/01/97 - 31/12/97	
	Male	Female	Male	Female
Homosexual contact	7	na	26	na
Heterosexual contact	1	1	2	5
IDU	1	-	1	-
Unknown/other	-	-	-	1
<b>Total</b>	<b>9</b>	<b>1</b>	<b>29</b>	<b>6</b>

na not applicable

**Table 1.2 HIV infection detected in South Australia between 01/10/97 - 31/12/97 and year to date. Testing history by age at diagnosis.**

Testing History	4th Quarter 01/10/97 - 31/12/97			Year to date 01/01/97 - 31/12/97			Total
	Age			Age			
	<25	25 - 39	40+	<25	25 - 39	40+	
<b>Male</b>							
Previous 12 months	-	3	1	2	6	2	10
12 - 24 months	1	-	1	1	4	4	9
No previous test	-	1	2	1	3	6	10
<b>Total</b>	1	4	4	4	13	12	29
<b>Female</b>							
Previous 12 months	-	-	-	1	1	-	2
12 - 24 months	-	-	-	-	-	-	-
No previous test	-	1	-	1	2	1	4
<b>Total</b>	-	1	-	2	3	1	6

**Table 1.3 Summary of HIV antibody tests performed between 01/10/97 - 31/12/97 and year to date. Laboratory by sex.**

Laboratory	4th Quarter 01/10/97 - 31/12/97			Year to date 01/01/97 - 31/12/97			Total
	Male	Female	Unknown	Male	Female	Unknown	
Public	6126	6540	298	25479	27963	817	54259
Private	2885	2736	-	9453	10928	-	20381
<b>Total</b>	9011	9276	298	34932	38891	817	74640

# HEPATITIS C SURVEILLANCE IN SOUTH AUSTRALIA

## Hepatitis C Medical Notification 01/10/97 - 31/12/97

In the fourth quarter of 1997, laboratory notifications of positive hepatitis C antibody tests were received for 343 individuals. Of these, 327 (96%) were notified by medical practitioners. Among the medical notifications, 110 (34%) cases were tested for hepatitis C for the first time, whilst 94 (29%) previously had a positive test. In 30 (9%) cases there was a previous negative test for hepatitis C antibodies, the testing history was unavailable in 93 (28%) cases.

Among the 233 individuals in whom antibodies to hepatitis C were detected for the first time in the fourth quarter, 154 (66%) reported past or present injecting drug use as a likely transmission route for hepatitis C virus (Table 2.1).

The majority of males, 124 (79%), were aged between 20 and 39 years; 45 (58%) women were aged between 20 and 39 years (Table 2.2).

Of the 30 individuals with a previous negative test, 10 were incident cases, with negative serology in the preceding 12 months. Four females and six males were identified as incident cases. The likely route of virus transmission in 8 cases was injecting drug use (Table 2.3).

Collated laboratory data for hepatitis C antibody tests performed during the quarter are shown in Table 2.4.

**Table 2.1 Hepatitis C infection detected between 01/10/97 - 31/12/97 and year to date. Exposure category by sex.**

Exposure Category	4th Quarter 01/10/97 - 31/12/97		Year to date 01/01/97 - 31/12/97		
	Male	Female	Male	Female	Total
IDU*	105	49	447	194	641
Blood transfusion/blood products	9	6	34	23	57
Tattoos	18	1	47	12	59
Other**	10	11	42	45	87
Unknown	14	10	76	34	110
<b>Total</b>	<b>156</b>	<b>77</b>	<b>646</b>	<b>308</b>	<b>954</b>

\* includes IDU, IDU/tattoos, IDU/tattoos/blood transfusion and IDU/blood transfusion.

\*\* includes - body piercing, residence in a high prevalence country, household contact, positive sexual partner, perinatal.

**Table 2.2 Hepatitis C infection detected between 01/10/97 - 31/12/97 and year to date. Age group by sex.**

Age Group	4th Quarter 01/10/97- 31/12/97		Year to date 01/01/97 - 31/12/97		
	Male	Female	Male	Female	Total
Under 10	-	-	-	3	3
10 - 19	2	7	10	22	32
20 - 29	57	18	177	74	251
30 - 39	67	27	272	121	393
40 - 49	21	16	139	46	185
50+	9	9	48	42	90
<b>Total</b>	156	77	646	308	954

**Table 2.3 Incident cases of hepatitis C infection detected between 01/10/97 - 31/12/97 and year to date. Exposure category by sex.**

Exposure Category	4th Quarter 01/10/97 - 31/12/97		Year to date 01/01/97 - 31/12/97		
	Male	Female	Male	Female	Total
IDU	5	3	30	13	43
Tattoos	-	-	1	-	1
Body piercing	1	-	1	-	1
Household	-	-	-	1	1
Unknown	-	1	3	2	5
<b>Total</b>	6	4	35	16	51

**Table 2.4 Summary of laboratory tests for hepatitis C antibodies performed between 01/10/97 - 31/12/97 and year to date. Laboratory by sex.**

Laboratory	4th Quarter 01/10/97 - 31/12/97			Year to date 01/01/97 - 31/12/97			
	Male	Female	Unknown	Male	Female	Unknown	Total
Public	4664	4130	218	18742	16744	547	36033
Private	2727	3397	-	10882	14090	-	24972
<b>Total</b>	7391	7527	218	29624	30834	547	61005

# HEPATITIS B SURVEILLANCE IN SOUTH AUSTRALIA

## Hepatitis B Medical Notification 01/10/97 - 31/12/97

During the fourth quarter of 1997, 76 hepatitis B medical notifications were received. Of these, six were acute clinical cases of hepatitis B infection (Tables 3.1, 3.2). A further 17 were reports of chronic carriers of greater than twelve months duration, who had been previously diagnosed but not notified. There were 2 reports of antigen positivity of less than 12 months duration (defined by a negative hepatitis B surface antigen test in the 12 months prior to diagnosis) (Table 3.3). Reports of antigen positivity of uncertain duration accounted for 51 cases (Table 3.3).

Of the 51 reports of antigen positivity of uncertain duration, 20 tested surface antigen positive for the first time this quarter, and the testing history was unknown for the remaining 31 cases. Among the 20 individuals who tested surface antigen positive for the first time, but were not acute cases, the racial origin of 13 (65%) was reported as Asian (Table 3.4).

The number of hepatitis B surface antigen tests performed by laboratories for this quarter is shown in Table 3.5.

**Table 3.1 Acute hepatitis B infection, 01/10/97 - 31/12/97 and year to date. Exposure category by sex.**

Exposure Category	4th Quarter 01/10/97 - 31/12/97		Year to date 01/01/97 - 31/12/97		
	Male	Female	Male	Female	Total
IDU	1	1	3	2	5
Heterosexual Contact	1	1	2	3	5
Social/Family	-	-	-	1	1
Unknown	2	-	6	1	7
<b>Total</b>	4	2	11	7	18

**Table 3.2 Acute hepatitis B infection, 01/10/97 - 31/12/97 and year to date. Age group by sex.**

Age Group	4th Quarter 01/10/97 - 31/12/97		Year to date 01/01/97 - 31/12/97		
	Male	Female	Male	Female	Total
10 - 19	-	1	-	1	1
20 - 29	1	1	4	3	7
30 - 39	3	-	6	1	7
50+	-	-	1	2	3
<b>Total</b>	4	2	11	7	18

**Table 3.3 Hepatitis B infection, 01/10/97 - 31/12/97 and year to date. Case category by sex.**

Case Category	4th Quarter 01/10/97 - 31/12/97		Year to date 01/01/97 - 31/12/97		
	Male	Female	Male	Female	Total
Acute Infection	4	2	11	7	18
Antigen positive - <12 months duration	1	1	1	1	2
Antigen positive - uncertain duration	38	13	163	82	245
Chronic carriers - >12 months duration	9	8	54	41	95
<b>Total</b>	52	24	229	131	360

**Table 3.4 Individuals who tested hepatitis B surface antigen positive for the first time, 01/10/97 - 31/12/97 and year to date. Race by sex.**

Racial Origin	4th Quarter 01/10/97 - 31/12/97		Year to date 01/01/97 - 31/12/97		
	Male	Female	Male	Female	Total
Aboriginal	-	-	8	1	9
Asian	8	5	45	24	69
Caucasian	5	2	23	18	41
Other/Unknown	-	-	6	2	8
<b>Total</b>	13	7	82	45	127

**Table 3.5 Summary of hepatitis B surface antigen tests performed between 01/10/97 - 31/12/97 and year to date. Laboratory by sex.**

Laboratory	4th Quarter 01/10/97 - 31/12/97			Cumulative 01/01/97 - 31/12/97			
	Male	Female	Unknown	Male	Female	Unknown	Total
Public	4467	5785	684	18389	25110	1043	44542
Private	2918	4787	-	10894	19654	-	30548
<b>Total</b>	7385	10572	684	29283	44764	1043	75090

## GENITAL CHLAMYDIAL INFECTION IN SOUTH AUSTRALIA

### Genital Chlamydial Infection 01/01/97 - 31/12/97

There were 1050 cases of genital chlamydial infection notified between 1 January and 31 December 1997 (Table 4.1). Of these, 402 (38%) cases occurred in males and 648 (62%) in females.

### Genital Chlamydial Infection 01/10/97 - 31/12/97

Between 1 October and 31 December 1997, 201 cases of chlamydial infection were notified to the STD Control Branch. This represents fewer cases of infection than reported in previous quarters of 1997.

Of the 201 cases of genital chlamydia, 91 (45%) occurred in males and 110 (55%) in females (Table 4.1). In males, 80 (88%) cases were under 35 years of age, and 108 (98%) cases occurred in females aged less than 35 years (Table 4.1).

Laboratory tests for genital chlamydia performed during this quarter are detailed in Table 4.2.

**Table 4.1 Genital chlamydial infection in South Australia, 01/10/97 - 31/12/97 and year to date. Age group by sex.**

Age Group	4th Quarter 01/10/97 - 31/12/97		Year to date 01/01/97 - 31/12/97		
	Male	Female	Male	Female	Total
10 - 14	-	3	2	8	10
15 - 19	19	38	75	195	270
20 - 24	30	40	144	241	385
25 - 29	20	18	91	101	192
30 - 34	11	9	41	43	84
35 - 39	6	1	23	29	52
40+	5	1	22	31	53
Unknown	-	-	4	-	4
<b>Total</b>	91	110	402	648	1050

**Table 4.2 Summary of laboratory tests for genital chlamydia performed between 01/10/97 - 31/12/97 and year to date. Laboratory by sex.**

Laboratory	4th Quarter 01/10/97 - 31/12/97		Year to date 01/01/97 - 31/12/97		
	Male	Female	Male	Female	Total
Public	1337	3013	5333	12400	17733
Private	570	2155	2342	9033	11375
<b>Total</b>	1907	5168	7675	21433	29108

# GONOCOCCAL INFECTION IN SOUTH AUSTRALIA

## Gonococcal Infection 01/01/97 - 31/12/97

There were 343 cases of gonococcal infection notified between 1 January and 31 December 1997 (Table 5.1).

## Gonococcal Infection 01/10/97 - 31/12/97

During the fourth quarter, 35 cases of gonorrhoea were reported to the STD Control Branch. There were fewer cases of gonococcal infection notified in this quarter than for previous quarters in 1997.

Twenty one (60%) cases of gonococcal infection occurred in males, and 14 (40%) in females. Stratification of females by age shows all 14 (100%) cases were aged less than 35 years. Infection in males was equally distributed by age (Table 5.1). No cases of conjunctival infection with gonorrhoea were reported during this quarter.

Of the 21 males, 3 (14%) reported male to male sexual contact. The majority (83%) of infections in males and females were acquired in South Australia.

**Table 5.1 Gonococcal infection detected in South Australia, 01/10/97 - 31/12/97 and year to date. Age group by sex.**

Age Group	4th Quarter 01/10/97 - 31/12/97		Year to date 01/01/97 - 31/12/97		
	Male	Female	Male	Female	Total
< 15	-	1	2	4	6
15 - 19	2	7	38	37	75
20 - 24	6	2	48	36	84
25 - 29	7	2	51	15	66
30 - 34	4	2	34	15	49
35 - 39	1	-	19	6	25
40+	1	-	23	8	31
Unknown	-	-	6	1	7
<b>Total</b>	21	14	221	122	343

## CLINIC 275 ACTIVITY REPORT

Table 6.1 Clinic 275 - Summary Statistics

Diagnosis	Period 01/10/97 - 31/12/97		Year to date 01/01/97 - 31/12/97		
	Male	Female	Male	Female	Total
No illness	488	365	2068	1489	3557
HIV	5	1	8	1	9
Gonorrhoea	4	-	50	4	54
Syphilis	-	-	3	-	3
Herpes	38	34	139	105	244
Chlamydia	38	12	124	70	194
NSU	35	na	124	na	124
Warts	221	81	852	324	1176
Trichomoniasis	1	1	1	5	6
Candida vaginitis	na	103	na	379	379
Crabs	28	8	121	30	151
Scabies	4	1	25	1	26
Molluscum	40	9	126	32	158
Bacterial vaginosis	-	43	-	197	197
Hepatitis B antigen positive	5	1	12	3	15
Hepatitis C infection	14	13	66	34	100
Urethral irritation	74	na	265	na	265
Balanitis	57	na	200	na	200
Non STD illness	125	42	518	219	737
Post coital contraception	na	59	na	188	188
Abnormal Pap smear	na	34	na	190	190
Other/Uncertain	16	7	94	84	178
<b>Clinic attendances</b>	2180	1383	8968	5663	14631
<b>Episodes of care</b>	1098	717	4458	2942	7400
<b>Individual clients</b>	725	491	3486	2321	5807

na not applicable

Note: A client may have more than one diagnosis for an episode of care. An individual client may have several episodes of care each requiring one or more attendances. Data on episodes of care and individual clients are from the computerised casenotes system based on date of first visit for an episode of care. Clinic attendances were obtained from the daybook for the time period covered by this report.

**Table 6.2 Males diagnosed with chlamydia, gonorrhoea or \*syphilis at C275, 01/10/97 - 31/12/97. Exposure category by infection**

Exposure Category	Chlamydia	Gonorrhoea	Total
Homosexual	-	1	1
Bisexual	1	1	2
Heterosexual, IDU	7	-	7
Heterosexual, overseas contact	1	2	3
Heterosexual	29	-	29
<b>Total</b>	<b>38</b>	<b>4</b>	<b>42</b>

\* No cases of syphilis were diagnosed during the quarter.

**Table 6.3 Males diagnosed with hepatitis C, hepatitis B or HIV infection at C275, 01/10/97 - 31/12/97. Exposure category by infection.**

Exposure Category	Hepatitis C	Hepatitis B* Previous exposure	Hepatitis B carrier	HIV	Total
Homosexual	-	7	1	3	11
Homosexual/IDU	2	3	-	-	5
Bisexual	-	2	-	-	2
Bisexual/IDU	2	-	-	-	2
Heterosexual, IDU	9	11	2	-	22
Heterosexual, o/s#	-	2	-	-	2
Heterosexual	-	10	2	-	12
Other/Unknown	1	2	-	1	4
<b>Total</b>	<b>14</b>	<b>37</b>	<b>5</b>	<b>4</b>	<b>60</b>

\* No case of acute hepatitis B diagnosed during the quarter.

\* Previous exposure to hepatitis B refers to previous infection and now surface antibody positive.

# Overseas contact in the previous three months.

**Table 6.4 Females diagnosed with chlamydia, \*gonorrhoea or syphilis at C275, 01/10/97 - 31/12/97. Exposure category by infection.**

Exposure Category	Chlamydia	Total
Heterosexual, IDU	2	2
Heterosexual	10	10
<b>Total</b>	<b>12</b>	<b>12</b>

\* No cases of gonorrhoea or syphilis were diagnosed during the quarter.

**Table 6.5 Females diagnosed with hepatitis C, hepatitis B or HIV infection at C275, 01/10/97 - 31/12/97. Exposure category by infection.**

<b>Exposure Category</b>	<b>Hepatitis C</b>	<b>Hepatitis B* Previous exposure</b>	<b>Hepatitis B carrier</b>	<b>HIV</b>	<b>Total</b>
Heterosexual, IDU	8	3	-	-	11
Heterosexual	1	3	1	1	6
Other/Unknown	4	3	-	-	7
<b>Total</b>	13	9	1	1	24

\* No case of acute hepatitis B diagnosed during reporting period.

\* Previous exposure to hepatitis B refers to previous infection and now surface antibody positive.

# Overseas contact in the previous three months.

The STD Control Branch Quarterly Surveillance Report is produced by the STD Control Branch, Public and Environmental Health Service, South Australian Health Commission. ISSN 1328-0090

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**All data in this report are provisional and subject to future revision.**