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SURVEILLANCE CASE DEFINITIONS

MARCH 1994

Endorsed at the 115th Session of NHMRC, Adelaide — June 1993

Report of the Public Health Committee

NHMRC

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A)

National notifiable diseases

Summary list

Arbovirus infection	Leptospirosis
— Dengue	Listeriosis
— Ross River virus infection	Lymphogranuloma venereum
— Arbovirus infection (NOS)	Malaria
Botulism (food borne)	Measles
Brucellosis	Meningococcal infection
Campylobacteriosis	Mumps
Chancroid	Pertussis
Chlamydial infection (NOS)	Plague
Cholera	Poliomyelitis
Diphtheria	Q fever
Donovanosis	Rabies
Gonococcal infection	Rubella
<i>Haemophilus influenzae</i> type b infection	— Rubella
Hepatitis A	— Congenital rubella
Hepatitis B	Salmonellosis (NOS)
Hepatitis C	Shigellosis
Hepatitis (NOS)	Syphilis
HIV infection	— Syphilis
— HIV infection	— Congenital syphilis
— AIDS	Tuberculosis
Hydatid infection	Typhoid and paratyphoid
Legionellosis	Viral haemorrhagic fever
Leprosy	Yellow fever
	Yersiniosis (NOS)

NOS = Not otherwise specified

Case definitions

- 1) Arbovirus infection AND one of the following:
- a) Demonstration of a four-fold or greater change in serum antibody titres between acute and convalescent-phase serum specimens obtained at least 2 weeks apart and preferably conducted at the same laboratory.
- Isolation of *Clostridium botulinum* from faeces or other clinical specimen
 - or
 - Detection of *C. botulinum* toxin in serum, faeces or a probable food source
 - or
 - Epidemiological linkage to other cases of confirmed foodborne botulism.
- OR
- b) Demonstration of specific IgM antibodies in CSF or acute-phase serum.
- OR
- c) Isolation of virus from blood, CSF or tissue specimens.
- 3) Brucellosis
- a) Isolation of *Brucella* species from a clinical specimen.
- OR
- 1.1) Dengue
- Demonstration of the above criteria for dengue virus (all types).
- b) A fourfold or greater change in *Brucella* agglutination titres or complement fixation titres between acute and convalescent-phase serum samples at least 2 weeks apart with the tests preferably conducted at the same laboratory.
- 1.2) Ross River virus infection
- Demonstration of the above criteria for RRV.
- OR
- 1.3) Arbovirus infection (NOS)
- Demonstration of the above criteria for:
- Alpha viruses — Sindbis, Barmah Forest,
Flaviviruses — Murray Valley encephalitis, Kunjin, Kokobera, Stratford.
- c) Demonstration of *Brucella* antigen in a clinical specimen.
- 4) Campylobacteriosis
- Isolation of *Campylobacter* species from a clinical specimen.
- 5) Chancroid
- a) Isolation of *Haemophilus ducreyi* from a clinical specimen.
- OR
- 2) Botulism (food borne)
- A clinically compatible illness (diplopia, blurred vision, muscle weakness, paralysis, or bulbar palsy) with a history of exposure to a probable food source in the absence of a contaminated wound;
- b) A clinically compatible illness characterised by painful genital ulceration and inflammatory inguinal adenopathy, where syphilis, granuloma inguinale and herpes simplex have been excluded.

OR

- c) A clinically compatible illness in a patient who is epidemiologically related to a laboratory confirmed case.

6) Chlamydial infection (NOS)

- a) Isolation of *Chlamydia trachomatis* from a clinical (genital) specimen.

OR

- b) Demonstration of *Chlamydia trachomatis* in a clinical (genital) specimen by antigen detection methods.

7) Cholera

An illness characterised by diarrhoea and/or vomiting.

AND

Isolation of toxigenic *Vibrio cholerae* serogroup 01 or 0139 from a clinical specimen.

8) Diphtheria

Isolation of toxigenic *Corynebacterium diphtheriae*

AND one of the following:

- Pharyngitis and/or laryngitis (with or without a membrane).
- or
- Toxic (cardiac or neurological) symptoms.

9) Donovanosis

- a) Demonstration of intracytoplasmic Donovan bodies on Wright or Giemsa stained smears or biopsies of clinical specimens.

OR

- b) A clinically compatible illness characterised by usually painless, beefy red, granulomatous or ulcerative lesions with rolled edges and a tendency to form scar tissue, where syphilis has been excluded.

10) Gonococcal infection

Isolation of *Neisseria gonorrhoeae* from a clinical specimen.

11) Haemophilus influenzae type b (Hib) infection

- a) An invasive clinically compatible illness (meningitis, epiglottitis, cellulitis, septic arthritis, osteomyelitis, pneumonia, pericarditis or septicaemia)

AND either:

- the isolation of *Haemophilus influenzae* type b (Hib) from blood
- or
- detection of *Haemophilus influenzae* type b antigen (in a clinical case)
- or
- detection of Gram-negative bacteria where the organism fails to grow in a clinical case.

OR

- b) A confident diagnosis of epiglottitis by direct vision, laryngoscope or X-ray.

12) Hepatitis A

- a) Anti-HAV IgM positive, in the absence of recent vaccination.

OR

- b) Demonstration of a clinical case of hepatitis (jaundice +/- elevated aminotransferase levels without a non-infectious cause)

AND

epidemiologically linked to a serologically confirmed case.

13) Hepatitis B

HBsAg positive

AND one of the following:

- Anti-HBc IgM positive
- or
- Demonstration of a clinical illness consistent with acute viral hepatitis (jaundice, elevated aminotransferase).

14) Hepatitis C

- a) Demonstration of documented seroconversion to HCV

OR

- b) • Demonstration of anti-HCV positive or HCV PCR positive
- and
- a clinical illness consistent with acute viral hepatitis
- and
- is not an acute case of hepatitis A, B, or D.

15) Hepatitis (NOS)

Any other viral hepatitis not classified here.

16) HIV infection

16.1) HIV infection

HIV antibody positive confirmed by a State or Territory HIV Reference Laboratory.

16.2) AIDS

Surveillance case definition as used by the National Centre in HIV Epidemiology and Clinical Research. See Appendix 1.

17) Hydatid infection

- a) Positive serological test for infection with *Echinococcus granulosus* in a patient with clinical, radiological or sonographic evidence of hydatid disease.

OR

- b) Identification of *Echinococcus granulosus* in cyst fluid or sputum.

OR

- c) Immunoelectrophoresis demonstrating arc 5 or three or more other arcs.

18) Legionellosis

A clinically compatible illness (fever, cough or pneumonia)

AND at least one of the following:

- Isolation of *Legionella* species from lung tissues, respiratory secretions, pleural fluid, blood or other tissues.
- or
- Demonstration of *Legionella* species antigens in lung tissue, respiratory secretions or pleural fluid.
- or
- A fourfold or greater rise in (IFA) titre against *Legionella* species, to at least 128, between acute and convalescent phase sera.
- or
- A stable high *Legionella* titre (at least 512) in convalescent phase serum.

19) Leprosy

- a) Enlarged dermal nerves with associated sensory loss

OR

- b) Demonstration of acid-fast bacilli in a skin, smear or biopsy specimen

OR

- c) A histological picture compatible with leprosy in a specimen.

20) Leptospirosis

- a) Isolation of *Leptospira* species from clinical specimens.

OR

- b) A fourfold or greater change in *Leptospira* agglutination titre between acute and convalescent phase sera obtained at least 2 weeks apart and preferably conducted at the same laboratory.

OR

- c) Demonstration of leptospiral antigen in a clinical specimen.

OR

- d) A single raised *Leptospira* agglutination titre with a clinically compatible illness.

21) Listeriosis

Isolation of *Listeria monocytogenes* from a site which is normally sterile, including fetal gastrointestinal contents.

22) Lymphogranulomavenereum

- a) Isolation of *Chhmydia frachomatis* serotype L1, L2 or L3 from a clinical specimen.

OR

- b) Demonstration (by immunofluorescence) of inclusion bodies in leucocytes aspirated from an inguinal lymph node (bubo).

OR

- c) A positive serological test for lymphogranuloma venereum strain of *Chhmydia frachomatis*, in the presence of a clinically compatible illness (one or more tender, fluctuant inguinal lymph nodes, or characteristic proctogenital lesions).

23) Malaria

Demonstration of malaria parasites (*Plasmodium* species) in a blood film.

24) Measles

- a) An illness characterised by all the following features:
- A generalised maculopapular rash lasting 3 or more days,
 - and**
 - A fever (at least 38°C if measured),
 - and**
 - cough or coryza or conjunctivitis or Koplik spots.

OR

- b) Demonstration of measles specific IgM antibody.

OR

- c) A fourfold or greater change in measles antibody titre between acute and convalescent-phase sera obtained at least 2 weeks apart, with the tests preferably conducted at the same laboratory.

OR

- d) Isolation of measles virus from a clinical specimen.

OR

- e) A clinically compatible case epidemiologically related to another case.

25) Meningococcal infection

- a) Isolation of *Neisseria meningitidis* from a normally sterile site.

OR

- b) Detection of meningococcal antigen in joints, blood or CSF.

OR

- c) Detection of gram negative intracellular diplococci in blood or CSF.

26) Mumps

- a) Isolation of mumps virus from a clinical specimen.

OR

- b) Significant rise in mumps antibody level by any standard serological assay, except following immunisation.

OR

- c) A clinically compatible illness (unilateral or bilateral swelling of the parotid or other salivary glands lasting 2 days or more without other apparent cause).

27) Pertussis

- a) Isolation of *Bordetella pertussis* from a clinical specimen.

OR

- b) Elevated *Bordetella pertussis*-specific IgA in serum or B pertussis antigen in a nasopharyngeal specimen using immunofluorescence with a history of clinically compatible illness.

OR

- c) An illness lasting 2 weeks or more

with one of the following:

- paroxysms of coughing, or
- inspiratory 'whoop' without other apparent cases, or
- post-tussive vomiting.

OR

- d) An illness characterised by a cough lasting at least 2 weeks in a patient who is epidemiologically related to a laboratory confirmed case.

28) Plague

- a) A fourfold or greater change in serum antibody titre for *Yersinia pestis*.

OR

- b) Isolation of *Y. pestis* from a clinical specimen.

29) Poliomyelitis

Acute onset of a flaccid paralysis of one or more limbs with decreased or absent tendon reflexes in the affected limbs without other apparent cause, and without sensory or cognitive loss.

30) Q fever

- a) A fourfold or greater change in serum (CF) antibody titre to phase II antigen of *Coxiella burnetii*.

OR

- b) A fourfold or greater change in enzyme-linked immunosorbent assay (ELISA) of antibody titre to phase I or II antigens of *C. burnetii*.

OR

- c) An IgM fluorescent antibody titre of at least 1:160 during the convalescent phase of the illness (i.e. 10 days or more after onset).

OR

- d) In chronic infections (e.g.: endocarditis), elevated (CF)IgG or IgA titres to *C. burnetii* phase I antigen.

OR

- e) Isolation of *C. burnetii* from a clinical specimen.

31) Rabies

- a) Clinically compatible neurological illness

AND either:

- Detection of viral antigens in tissue.
or
- Isolation of rabies virus from saliva, skin snips, CSF or neural tissue.

OR

- b) Detection of rabies neutralising antibody at a titre of at least 1:5 in serum or CSF (provided the patient is not immunised).

32) Rubella

32.1) Rubella

- a) A generalised maculopapular rash and a fever,

AND one or more of:

- arthralgia/arthritis
or
- lymphadenopathy
or
- conjunctivitis.

AND an epidemiological link to a confirmed case.

OR

- b) Demonstration of rubella-specific IgM antibody, except following immunisation.

OR

- b) A fourfold or greater change in rubella antibody titre between acute and convalescent-phase sera obtained at least 2 weeks apart.

OR

- c) Isolation of rubella virus from a clinical specimen.

32.2) Congenital rubella syndrome

A live or stillborn infant with clinically compatible defects (cataracts, congenital glaucoma, congenital heart disease, hearing defects, microcephaly, pigmentary retinopathy, mental retardation, purpura, hepatosplenomegaly, meningoencephalitis, radiolucent bone disease)

AND at least one of the following:

- Isolation of rubella virus from a clinical specimen from the infant.
or
- Demonstration of rubella-specific IgM antibody in the infant's serum.
or
- Persistence of rubella-specific IgG antibody of titre higher than expected from passive transfer of maternal antibody.
or
- Laboratory confirmed maternal rubella infection in the first trimester of pregnancy.

33) Salmonellosis (NOS)

Isolation of *Salmonella* species (excluding *S. typhi*, and *S. paratyphi*) from any clinical specimen.

34) Shigellosis

Isolation of *Shigella* species from any clinical specimen.

35) Syphilis

35.1) Syphilis

A compatible clinical illness or past history

AND

- Demonstration of *Treponema pallidum* in clinical specimens by darkfield, fluorescent antibody, or equivalent microscopic methods.
- or
- Reactive treponemal tests (e.g. FTA-ABS,TPHA).

35.2) Congenital syphilis

Demonstration of a clinical syndrome and serological evidence consistent with syphilis.

36) Tetanus

A clinically compatible illness without other apparent cause, with or without a history of injury, and with or without laboratory evidence of the organism or its toxin.

37) Tuberculosis

- a) Isolation of *Mycobacterium tuberculosis*, *Mycobacterium bovis* or *Mycobacterium africanum* from a clinical specimen.

OR

- b) Demonstration of acid-fast bacilli in a clinical specimen or in a histopathological lesion when a culture is not available, in a person with signs or symptoms compatible with tuberculosis.

OR

- c) Evidence of resolution of disease where treatment with two or more antituberculosis medications have been prescribed and follow-up has been instigated.

38) Typhoid and paratyphoid

- a) Isolation of *Salmonella typhi* from any clinical specimen.

OR

- b) Isolation of *Salmonella paratyphi* serotype A, B or C from any clinical specimen.

39) Viral haemorrhagic fever

Sudden or insidious onset of fever, headache, nausea, vomiting, diarrhoea, multifocal haemorrhages and shock. An appropriate travel history to an endemic country is supportive of the diagnosis,

AND one of the following:

- Demonstration of specific IgM antibody by ELISA, IFA or Western blot;
- or
- Isolation of virus in cell culture;
- or
- Demonstration of viral antigen in a tissue specimen;

to Ebola virus, Lassa fever virus, Marburg virus or Crimean Congo virus.

40) Yellow fever

A clinically compatible illness

AND

- Demonstration of yellow fever virus, antigen or genome in any clinical specimen.
or
- A fourfold or greater change in serum antibody titre to yellow fever virus,
or
a single elevated yellow fever specific IgM antibody titre, where cross-reaction with other flaviviruses has been ruled out and the patient has not received yellow fever vaccine during the previous 2 months.

OR

- b) Detection of circulating antigen by ELISA or agglutination test.

OR

- c) Positive *Yersinia* serology in the presence of clinical compatible illness.

41) Yersiniosis (NOS)

- a) Isolation of *Yersinia enterocolitica* or *Y. pseudotuberculosis* from the patient's faeces or blood.

B) Other diseases under surveillance

1) Non-tuberculous atypical mycobacterial infection

An active case of non-tuberculous mycobacterial disease is when there are clinical features consistent with one or more of the following:

- presence of compatible disease process which is clinically, radiologically and/or pathologically not due to other causes.
or
- consistent repeated recovery of the same non-tuberculous *Mycobacterium* for the same site in moderate to abundant amounts.
or
- recovery of non-tuberculous *Mycobacterium* from sites which are normally sterile.

ANCA

Australian National Council on AIDS

BULLETIN

No 18

DEFINITION OF HIV INFECTION AND AIDS-DEFINING ILLNESSES

The Intergovernmental Committee on AIDS (IGCA), representing the Commonwealth and all Australian State and Territory Health Departments, in consultation with the National Centre for HIV Epidemiology and Clinical Research (NCHECR) and the Communicable Diseases Network-Australia/New Zealand, has agreed to modify the AIDS case definition in Australia by the addition of the following three clinical conditions:

pulmonary tuberculosis;
recurrent pneumonia; and
invasive cervical cancer.

The new definition is effective in Australia from 1 January 1993.

The complete Australian HIV definition and AIDS defining illnesses definitions are listed below.

DEFINITION OF HIV INFECTION

(i) Repeatedly reactive screening tests for HIV antibody, confirmed by the use of supplementary tests*;

or

(ii) direct identification of HIV by virus isolation.

*Supplementary (or confirmatory) test: a test with higher specificity for detection of HIV antibody than screening (or first line) tests.

DEFINITION OF AIDS-DEFINING ILLNESSES

Candidiasis of the bronchi, trachea or lungs - definitive diagnosis only

Gross inspection by endoscopy or autopsy or by microscopy (histology or cytology) on a specimen obtained directly from the tissues affected (including scrapings from the mucosal surface), not from a culture.

Oesophageal candidiasis - definitive or presumptive diagnosis

Definitive diagnosis: as for candidiasis of the bronchi, trachea or lungs. Presumptive diagnosis:

- (i) recent onset of retrosternal pain on swallowing; and
- (ii) oral candidiasis diagnosed by the gross appearance of white patches or plaques on an erythematous base or by the microscopic appearance of fungal mycelial filaments in an uncultured specimen scraped from the oral mucosa.

Invasive cervical cancer - definitive diagnosis only

Histological evidence of cancer.

Coccidioidomycosis, disseminated or extrapulmonary - definitive diagnosis only

Microscopy (histology or cytology), culture or detection of antigen in a specimen obtained directly from the tissues affected or a fluid from those tissues.

Cryptococcosis, extrapulmonary - definitive diagnosis only

Microscopy (histology or cytology), culture or detection of antigen in a specimen obtained directly from the tissues affected or a fluid from those tissues.

Cryptosporidiosis, of more than one month's duration - definitive diagnosis only

Microscopy (histology or cytology), culture or detection of antigen in a specimen obtained directly from the tissues affected or a fluid from those tissues.

Cytomegalovirus disease, other than liver, spleen or lymph nodes - definitive diagnosis only

Microscopy (histology or cytology), culture or detection of antigen in a specimen obtained directly from the tissues affected or a fluid from those tissues.

Cytomegalovirus retinitis, with loss of vision - definitive or presumptive diagnosis

Definitive diagnosis: as for cytomegalovirus disease, other than liver, spleen or lymph nodes.

Presumptive diagnosis: A characteristic appearance on serial ophthalmoscopic examinations, for example discrete patches of retinal whitening with distinct borders, spreading in a centrifugal manner along the paths of blood vessels, progressing over several months, and frequently associated with retinal vasculitis, haemorrhage, and necrosis. Resolution of active disease leaves retinal scarring and atrophy with retinal pigment epithelial mottling.

Encephalopathy, HIV related - definitive diagnosis only

Clinical findings of disabling cognitive or motor dysfunction interfering with occupation or activities of daily living, progressing over weeks to months, in the absence of a concurrent illness or condition other than HIV infection that could explain the findings. Methods to rule out such concurrent illness and conditions must include cerebrospinal fluid examination and either brain imaging (computed tomography or magnetic resonance) or autopsy.

Herpes simplex: chronic ulcer(s) of more than one month's duration, bronchitis, pneumonitis or oesophagitis - definitive diagnosis only

Microscopy (histology or cytology), culture or detection of antigen in a specimen obtained directly from the tissues affected or a fluid from those tissues.

Histoplasmosis, disseminated or extrapulmonary - definitive diagnosis only

Microscopy (histology or cytology), culture or detection of antigen in a specimen obtained directly from the tissues affected or a fluid from those tissues.

Isosporiasis, chronic intestinal, of more than one month's duration - definitive diagnosis only

Microscopy (histology or cytology).

Kaposi's sarcoma - definitive or presumptive diagnosis

Definitive diagnosis: Microscopy (histology or cytology).

Presumptive diagnosis: A characteristic gross appearance of an erythematous or violaceous plaque-like lesion on skin or mucous membrane. Note: Presumptive diagnosis of Kaposi's sarcoma should not be made by clinicians who have seen few cases of it.

Lymphoma, Burkitt's - definitive diagnosis only

Microscopy (histology or cytology).

Lymphoma, immunoblastic - definitive diagnosis only

Microscopy (histology or cytology).

Lymphoma, primary, of brain - definitive diagnosis only

Microscopy (histology or cytology).

***Mycobacterium tuberculosis* complex, any site, pulmonary or extrapulmonary - definitive or presumptive diagnosis**

Definitive diagnosis: Isolation (or culture if preferred terminology) of *Mycobacterium tuberculosis*, *Mycobacterium bovis* or *Mycobacterium africanum* from a clinical specimen.

Presumptive Diagnosis: Demonstration of acid-fast bacilli in a clinical specimen or in a histopathological lesion when a culture is not available, in a person with signs or symptoms compatible with tuberculosis; or evidence of resolution of disease where treatment with two or more antituberculosis medications have been prescribed and follow-up has been instigated.

Non-tuberculous mycobacterial disease, disseminated or extrapulmonary - definitive or presumptive diagnosis

Definitive diagnosis: Culture

Presumptive diagnosis: Microscopy of a specimen from normally sterile body fluids, or tissue from a site other than lungs, skin or cervical or hilar lymph nodes that shows acid-fast bacilli of a species not identified by culture, in a person with signs, symptoms or immunological profile compatible with disseminated disease.

***Pneumocystis carinii* pneumonia - definitive or presumptive diagnosis**

Definitive diagnosis: Microscopy (histology).

Presumptive diagnosis:

- (i) a history of dyspnoea on exertion or non-productive cough of recent onset (within the past three months); and
- (ii) chest x-ray evidence of diffuse bilateral interstitial infiltrates or evidence by gallium scan of diffuse bilateral pulmonary disease; and
- (iii) arterial blood gas analysis showing an arterial pO₂ of <70mm Hg or a low respiratory diffusing capacity (<80% of predicted values) or an increase in the alveolar-arterial oxygen tension gradient; and
- (iv) no evidence of a bacterial pneumonia.

Pneumonia, recurrent bacterial - definitive or presumptive

Definitive diagnosis: Two or more episodes occurring within a 12 month interval, of acute (new x-ray evidence, not present earlier) pneumonia. Both episodes must have culture (or other organism specific diagnostic method) proven infection with a pathogen that typically causes pneumonia (other than *Pneumocystis carinii* or *Mycobacterium tuberculosis*) and radiological evidence of pneumonia.

Presumptive diagnosis: Two or more episodes occurring within a 12 month interval of acute (new symptoms, signs or x-ray evidence not present earlier) pneumonia, based on clinical or radiological evidence.

Progressive multifocal leukoencephalopathy - definitive diagnosis only

Microscopy (histology or cytology).

Salmonella septicemia, recurrent - definitive diagnosis only

Culture proven infection with *Salmonella* species.

Toxoplasmosis - definitive or presumptive diagnosis

Definitive diagnosis: Microscopy (histology or cytology).

Presumptive diagnosis: Toxoplasmosis of brain

- (i) recent onset of a focal neurological abnormality consistent with intracranial disease or a reduced level of consciousness; and
- (ii) evidence by brain imaging (computed tomography or nuclear magnetic resonance) of a lesion having a mass effect or the radiographical appearance of which is enhanced by injection of contrast medium; and
- (iii) serum antibody to toxoplasmosis or successful response to therapy for toxoplasmosis.

Wasting syndrome due to HIV infection - definitive diagnosis only

Findings of profound involuntary weight loss of >10% of baseline body weight plus either chronic diarrhoea (at least two loose stools per day for ≥ 30 days), or chronic weakness and documented fever (for ≥ 30 days, intermittent or constant) in the absence of a concurrent illness or condition other than HIV infection that could explain the findings (for example cancer, tuberculosis, cryptosporidiosis or other specific enteritis).

Bacterial infection affecting a child less than 13 years of age - definitive diagnosis only

Laboratory diagnosis of multiple or recurrent bacterial infection (any combination of at least two within a 2-year period) of the following types: septicaemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses), caused by *Haemophihs*, *Streptococcus* (including *Pneumococcus*) or other pyogenic bacteria.

Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia affecting a child less than 13 years of age - definitive or presumptive diagnosis

Definitive diagnosis: Microscopy (histology or cytology).

Presumptive diagnosis: Lymphoid interstitial pneumonia - bilateral reticulonodular interstitial pulmonary infiltrates present on chest x-ray for two months or more, with no pathogen identified and no response to antibiotic treatment. Other causes of interstitial infiltrates should be excluded, such as tuberculosis, *Pneumocystis carinii* pneumonia, cytomegalovirus infection or other viral or parasitic infections.

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April 1994



THE NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL

The National Health and Medical Research Council (NHMRC) became a statutory body within the portfolio of the Commonwealth Minister for Health, established by the *National Health and Medical Research Council Act 1992*. The NHMRC advises the Australian community and Commonwealth, State and Territory Governments on standards of individual and public health, and supports research to improve those standards.

The NHMRC advises the Commonwealth Government on the funding of medical and public health research and training in Australia and supports many of the medical advances made by Australians.

The Council comprises nominees of Commonwealth, State and Territory health authorities, professional and scientific colleges and associations, unions, universities, business, consumer groups, welfare organisations, conservation groups and the Aboriginal and Torres Strait Islander Commission.

The Council meets twice a year to consider and make decisions on reports prepared by committees and working parties following wide consultation on the issue under consideration.

A regular publishing program ensures that Council's recommendations are widely available to governments, the community, scientific, industrial and educational groups.

The Council publishes extensively in the following areas:

- Child Health • Clinical Practice • Communicable Diseases • Dentistry
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