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Strongyloidiasis: a case for notification in Australia?

To the Editor: Australia's National Notifiable Diseases Surveillance System (NNDSS) is used to monitor trends in 58 communicable diseases or conditions. The incidence of notifiable diseases can be decreased by public health action. Some diseases require rapid local responses, such as outbreaks of vaccine-preventable or foodborne diseases. Upward trends in the incidence of other notifiable diseases — for example, tuberculosis, sexually transmitted infections and bloodborne viruses — can be managed by less-rapid responses. The NNDSS exists not for data collection per se, but for public health action.

The NNDSS is a dynamic tool of great value in specific diseases, particularly when control or elimination programs are being implemented, such as for hydatid disease, polio and measles. Diseases and conditions can be added or removed as required by the need for public health action.

Currently, Aboriginal people in rural and remote communities have a very high prevalence of strongyloidiasis, a lifelong disease caused by infection with the gastrointestinal nematode *Strongyloides stercoralis*.[1] This parasite is very rare in mainstream Australian communities and is generally acquired overseas or from outback Indigenous communities. Prevalence in many Indigenous communities is 15% or greater, and laboratory records indicate that the infection is widespread in Indigenous communities in Queensland, the Northern Territory, Western Australia, northern South Australia and northern New South Wales.[2,3] However, the epidemiological picture is patchy because data are not routinely collected.[4,5] Management of individual Indigenous patients appears to be inadequate — many do not receive appropriate treatment, with potentially fatal consequences.[5] A recent systematic literature review of strongyloidiasis in Indigenous Australians highlighted lack of data as one of the major barriers to controlling and eliminating the disease.[5] Strongyloidiasis can be easily and cheaply cured by oral ivermectin at individual patient and community levels.[1]

We urge the Australian Government Department of Health to consider placing strongyloidiasis on the NNDSS, in order to establish an accurate estimate of incidence that will inform the necessary public health action at community, regional and national levels. We propose that all reported cases be laboratory confirmed, based on faecal examination or serology.[6,7] These data can be collated and used to guide implementation of a national strongyloidiasis elimination program.

Richard Speare BVSc, PhD, DVSc[1,2]

Adrian Miller BA, MPH[3]

Wendy A Page MPHTM, FRACGP, FACRRM[4]

1 Tropical Health Solutions, Townsville, QLD.

2 James Cook University, Townsville, QLD.

3 Griffith University, Brisbane, QLD.

4 Miwatj Health Aboriginal Corporation, Nhulunbuy, NT.

richard.speare@jcu.edu.au

> “Prevalence in many Indigenous communities is 15% or greater”
>
> Speare et al

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Inappropriate pathology ordering and pathology stewardship

To the Editor: We commend Spelman's insightful discussion of the need for pathology stewardship.[1]

The Royal College of Pathologists of Australasia (RCPA) advocates a structured approach underpinned by national standards, aimed at minimising harm to patients as well as reducing laboratory and hospital costs. The College recommends hospital pathology stewardship programs with multidisciplinary input; harmonisation of testing and reporting; electronic decision support systems; educational strategies; and collection and analysis of national and state data.

Within this advocacy framework, the RCPA has led or collaborated on many projects relating to harmonisation, standardisation and structuring of reports, consumer benefits and risks, effective communication of results, point-of-care testing, quality of genetic testing (http://www.health.gov.au/internet/main/publishing.nsf/Content/pathology-qupp-index), and a free online educational tool for doctors (http://investigate.med.unsw.edu.au/home.jsf). The College advocates and advises on pathology rotations for junior doctors.

The RCPA Manual (http://www.rcpa.edu.au/Library/Practising-Pathology/RCPA-Manual/Home) provides decision support tools and comprehensive guidance on use and interpretation of pathology investigations.

While these initiatives will promote quality use of pathology,

we stress that coordinated support from major national institutions is needed to effect real change.

Peter Stewart MBA, FRACP, FRCPA[1]

Raymond C Chan PhD, FRACP, FRCPA[2]

Wendy Pryor PhD, FRCPA[1]

1 Royal College of Pathologists of Australasia, Sydney, NSW.

2 Royal Prince Alfred Hospital, Sydney, NSW.

wendyp@rcpa.edu.au

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General practitioner management of notifiable diseases is central to communicable disease control

To the Editor: Public health units routinely carry out investigations into cases of notifiable diseases, specified by state and territory Public Health Acts, because of the potential impact on the health of the public. Investigations involve contacting individuals and their contacts, and providing advice for follow up and treatment. This may include seeing a general practitioner for further testing, treatment, or prophylaxis of contacts.[1] To assess the extent of input from GPs in managing notifiable diseases we documented GP encounters related to public health unit communicable disease control activity in inner-western and south-western Sydney.

Visits to general practitioners and tests associated with communicable disease investigations

Condition or infection investigated (suspected and confirmed cases)	No. of investigations	Average no. of visits per investigation	Average no. of tests per investigation
High-level GP input			
Influenza outbreak*	5	14.8	20.2
Typhoid	1	9.0	17.0
Gastroenteritis outbreak†	17	2.1	3.7
Rubella	2	1.5	1.0
Hepatitis E	8	1.4	1.4
Measles	24	1.0	1.6
Varicella	1	1.0	1.0
Arbovirus	19	0.9	0.8
Pertussis	18	0.9	0.7
Legionella	9	0.8	0.9
Intermittent GP input			
Hepatitis A	4	0.5	0.5
Q fever	2	0.5	1.0
MERS Co-V	2	0.5	1.0
Hepatitis B	7	0.4	0.4
Malaria	3	0.3	0.3
Shigella	11	0.2	0.3
< 16 Chlamydia‡	6	0.2	0.0
Salmonella	9	0.1	0.1
Cryptosporidiosis	11	0.1	0.0
No GP input			
Rotavirus	5	0.0	0.0
Mumps	5	0.0	0.2
Meningococcal	7	0.0	0.0
Lymphogranuloma venereum	1	0.0	0.0
Invasive pneumoccocal disease	22	0.0	0.0
Hepatitis D	3	0.0	0.0
Hepatitis C	2	0.0	0.0
Haemophilis influenzae B	1	0.0	0.0
Diphtheria	4	0.0	0.5
Creutzfeldt–Jacob disease	1	0.0	0.0
Brucellosis	2	0.0	0.0
< 16 Gonorrhoea‡	1	0.0	0.0

MERS Co V = Middle East Respiratory syndrome (MERS) coronavirus.
* Three or more epidemiologically linked cases of Influenza-like Illness in residents or staff of child care or aged care facilities within 72 hours PLUS at least one case with a positive laboratory test result OR at least two cases with a positive point-of-care test. † Two or more cases of vomiting or diarrhoea in an institution are followed up as a possible outbreak. ‡ Conditions followed up in children aged under 16 years only to ensure they are not at risk. ◆