NORTHERN TERRITORY GOVERNMENT

# Centre for Disease Control

NT HEALTH

## Surveillance Update

Issued: June 2025

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## Communicable diseases in returned travellers – especially measles

- Clinicians need to be aware of communicable diseases that may present in returned travellers. Always take a travel history (**both international and interstate**) and promote travel vaccinations.
- In January 2025 there was a measles case notified in a returned traveller from Indonesia in the NT. There have been 77 cases of measles in returned travellers to Australia since the beginning of 2025, in the setting of outbreaks occurring in multiple countries including. Pakistan, Indonesia, Vietnam, Thailand, India, Africa, Europe and the United Kingdom (UK), the Middle East, and North America.
- Measles is characterised by a prodrome of fever, cough, runny nose and conjunctivitis, followed 2-4 days later by a non-itchy maculopapular rash commencing on the neck or face. Cases are infectious from a day before the fever starts until 4 days after the commencement of the rash.
- Measles is best diagnosed by **PCR on throat and nose swabs, and urine. Please contact NT CDC if you suspect measles.** Ask suspect cases to wear a surgical mask and see them in a separate room that can be kept empty for 30 minutes afterwards. Avoid sending potentially infectious patients to pathology providers, and if the patient is unwell and required to attend ED please call ahead to alert the staff.
- See CDC website for more information: Measles - GP Factsheet | NT Health
- In addition to measles, other diseases causing fever to be considered in returned travellers include, but are not limited to, dengue, Zika virus, malaria, typhoid fever, paratyphoid fever, hepatitis A, and mpox. Always consider travel-related diseases in your fever differential diagnosis.

## Ongoing syphilis outbreak

- An infectious syphilis outbreak has been ongoing in the NT since 2013, with over 2,500 cases notified as at 29 May 2025. There has been an increase in cases since June 2024 (Figure 3).
- Untreated syphilis can have devastating consequences in pregnancy, leading to miscarriage, stillbirth, neonatal death, low birth weight and congenital syphilis.
- Common presentations of infectious syphilis in adults include painless oral, ano-genital ulcer/s (occasionally painful), regional lymph node enlargement, rashes that can involve palms and soles, patchy hair loss, fever, sore throat and fleshy lesions resembling genital warts, ocular involvement and transaminitis.
- Congenital syphilis, a preventable condition, is caused by untreated maternal syphilis infection and can lead to serious lifelong sequelae and death.


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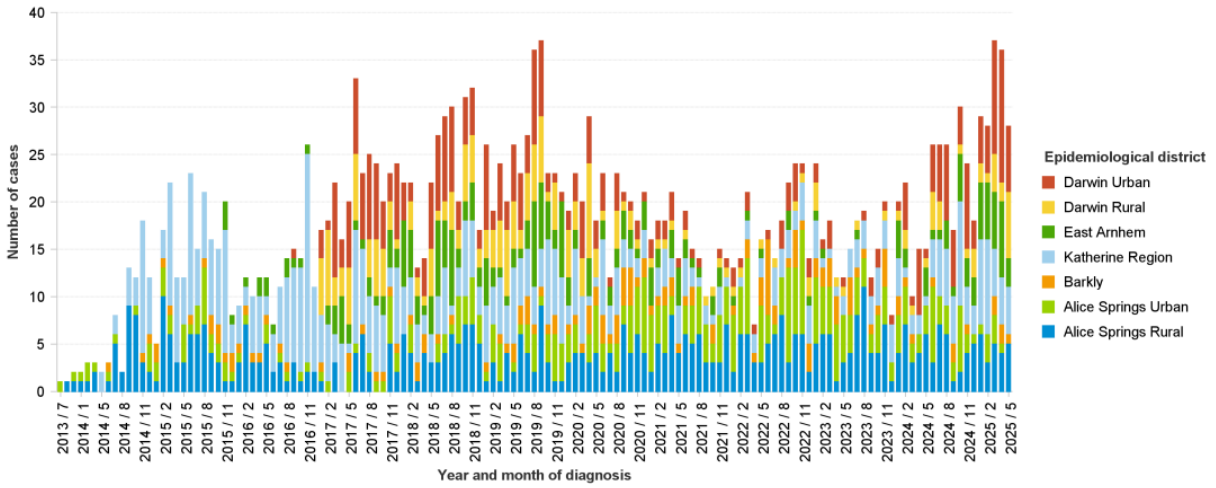
- In February 2025, the NT Health Chief Health Officer commissioned a Syphilis Incident Management Team (IMT) in response to the ongoing and rising rates of infectious syphilis
- The IMT recommended implementing simplified and consistent testing recommendations to increase syphilis testing and diagnosis. The following was supported by the CHO, Chief Medical Officer, Chief Aboriginal Health Practitioner and Chief Nurse Midwifery Officer:
    - Increased syphilis testing for ALL pregnant people to 5 times (first visit, 28 weeks, 36 weeks, at birth, and at 6 weeks postnatal), and
    - Syphilis testing for ALL people aged 15 years and over presenting to ANY health service, including NT Health primary health care, ACCHOs, Emergency Departments, Prison Health, private GP practices.
- Treat all symptomatic people and contacts with:
- Benzathine penicillin 2.4 million units IM stat (2 pre-filled syringes).

***Figure 3: Syphilis outbreak cases by epidemiological district, year and month of diagnosis, Northern Territory, 1 July 2013 – 30 May 2025.***




- Perform syphilis/HIV serology at the same time but do not wait for serology results to commence treatment.
- Collect dry swabs from all genital ulcers/lesions for Syphilis PCR (NAAT).
- If Point of Care Test (POCT) is positive for syphilis with no previous positive serology, **treat immediately** and perform syphilis/HIV serology.
- All sexually active heterosexual people under the age of 35 years require at least one full STI screen each year that includes testing for chlamydia, gonorrhoea, trichomoniasis, syphilis and HIV.
- Please call the NT Syphilis Register (Darwin 8922 7818 / Alice Springs 8951 7552) for the interpretation of Syphilis serology results and treatment history. The Syphilis Register has extended hours:
    - 5-9pm weekdays and 9am-9pm weekends
    - Call Royal Darwin Hospital Switch after hours 89228888
- You can also refer to the ASHM Decision Making in Syphilis resource.

## The Australian pertussis epidemic continues

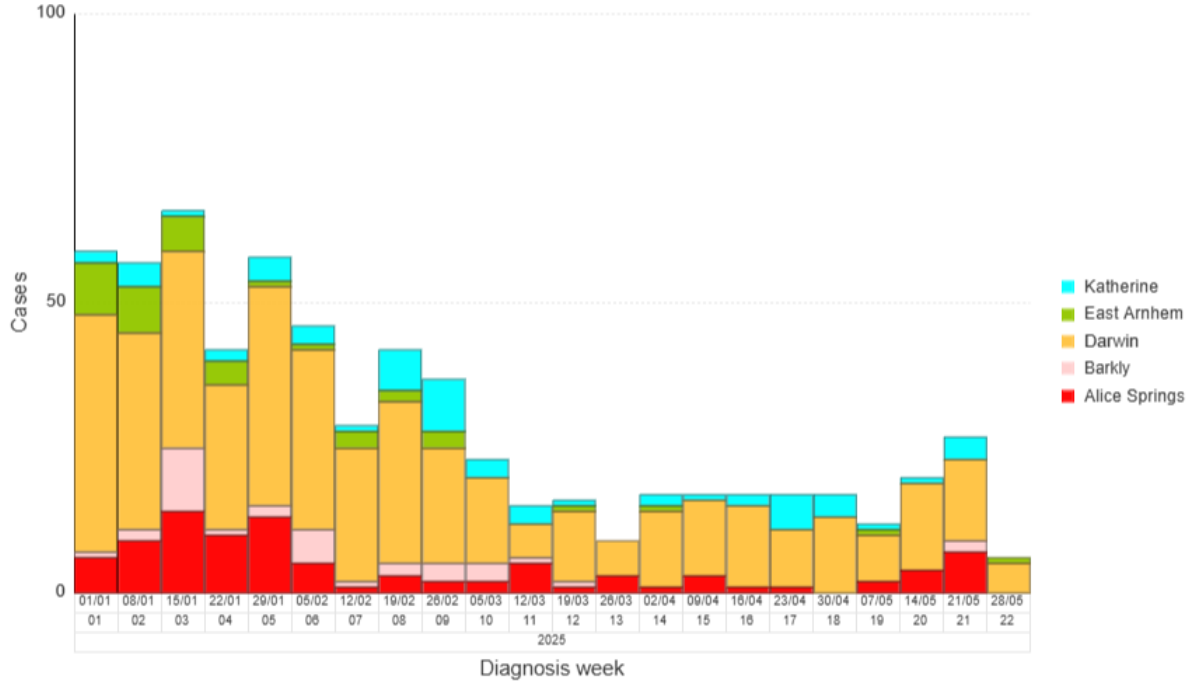
- To date there have been 50 notifications of pertussis across the NT, which is over 8 times the expected number of 6 cases notified by this time. Most cases (68%) have been in children less than 18 years old with 20% of all cases aged less than 1 year old, an age group most at risk of severe disease.

- Over 57 000 cases of pertussis were notified nationally in 2024 (the most ever recorded in a single year since pertussis became notifiable) with almost 14,000 notified so far in 2025. Pertussis remains an ongoing threat to susceptible Territorians.
- Pertussis is an infectious respiratory disease, characterised by a 'whooping' cough in babies and young children, and a persistent cough in older children and adults. Most hospitalisations and deaths from pertussis occur in babies and young children.
- The best protection against pertussis is to be up to date with vaccinations. Check your patient's vaccination status and update them per the recommended schedule, which **includes antenatal vaccination from 20 weeks gestation for each and every pregnancy**. See here for more information on vaccination: Pertussis (whooping cough) | The Australian Immunisation Handbook
- Testing for pertussis is recommended (PCR test is preferred) for patients presenting with cough prior to starting antibiotics. People with pertussis should stay home from school, childcare or work until they have completed 5 days of appropriate antibiotics or for 3 weeks from the onset date of coughing.
- Antibiotic prophylaxis is recommended for some people exposed to pertussis, including infants less than 6 months old and for contacts who may transmit pertussis to infants less than 6 months of age.
- See here for more information about pertussis: Pertussis – General Practitioner factsheet

## Respiratory viruses – COVID-19 and influenza

- COVID-19 continues in the NT with 646 notifications so far in 2025 (see Figure 1) with 34% of those cases hospitalised.
- A new variant of COVID-19 (NB1.8.1 variant) has been designated by the World Health Organization (WHO) as a "variant under monitoring". There have been cases detected in every Australian jurisdiction, including the NT.

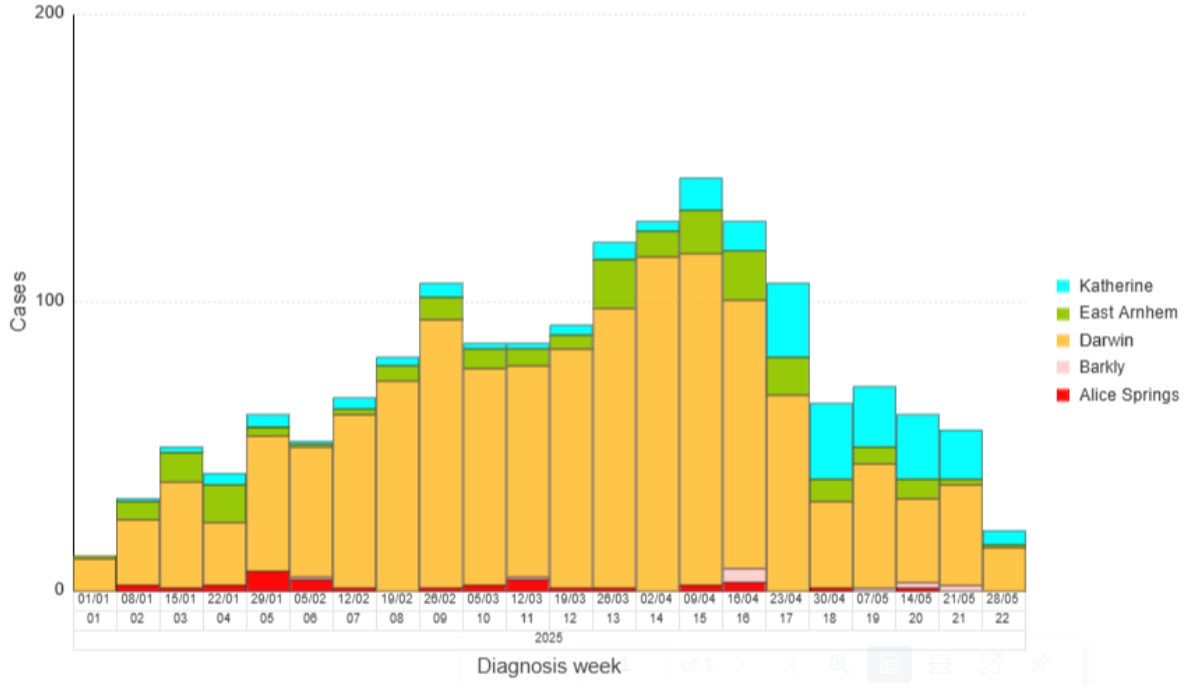
***Figure 1: COVID-19 notifications by week, Northern Territory, 1 January to 30 May 2025***




- Influenza notifications in the NT peaked in mid-April 2025 (Figure 2) and have been declining thereafter. There have been 1,668 notifications so far in 2025; 26% of whom required hospitalisation. There have been 4 deaths reported.

- The best strategy to control respiratory viruses is to test, treat, vaccinate (where relevant), and prevent spread.
- **Treat –** consider antivirals for COVID-19 and influenza for patients at higher risk for severe disease, or who are moderately unwell or deteriorating.
- **Vaccinate –** vaccines are widely available for COVID-19 and influenza, and RSV vaccines available to people over the age of 60 as well as to pregnant women between 28-36 weeks of gestation.

***Figure 2: Influenza notifications by week, Northern Territory, 1 January to 30 May 2025***




- **COVID-19** – people 18 years and older are eligible for annual boosters, and they are recommended for people aged 65 years and older and for people aged 18 years and over who are immunocompromised. See this page for information about primary and booster dose eligibility: COVID-19 vaccine advice and recommendations.
- **Influenza –** 2025 influenza vaccines are available from GP's, health clinics, and selected pharmacies, and are free for Aboriginal and Torres Strait Islander people, children under 5 years old, people 65 years and older, pregnant women, and people with certain chronic medical conditions. More information is available here: NT Immunisation Schedule Influenza March 2025
- **Prevent spread –** encourage patients with respiratory symptoms to stay home from childcare, school, work, and places where there may be vulnerable people until symptoms have resolved and educate them on disposing of used tissues and hand hygiene.
- To assist in national syndromic surveillance of respiratory viruses we encourage everyone to participate in FluTracking. The survey takes 20 seconds or less to complete each week and asks about symptoms of respiratory diseases. Find out more and register at: www.flutracking.net

## Mpox

- There have been over 1,700 cases of mpox notified in Australia since the beginning of 2022 with over 1,400 cases notified in 2024 alone. In 2025 case numbers have been decreasing nationally. The NT had 4 cases of mpox notified in 2024 of which none resulted in onward spread.
- Health authorities first detected mpox in Australia in 2022. Until now, reported cases of mpox in Australia had been caused by mpox clade IIb.

- In May 2025, Australia confirmed the nation's first case of mpox clade Ib in a person returned from overseas. There was low risk of further transmission linked to this case.
- Mpox clade I has generally been considered to cause more severe disease than clade II. Recent data suggests the case fatality rate for clade Ib is lower than that of clade Ia and similar to that of clade IIb.
- Mpox virus is spread through close contact with sores, bodily fluids, and contaminated objects. This may occur during sexual activities but can also occur through other types of physical contact.
- Symptoms include a distinctive rash, lesions, ulcers, swollen lymph nodes, fever, headaches, muscle aches, and fatigue. Rashes and lesions often begin in the genito-anal areas, but may also involve the face, body, hands and feet, and inside the mouth. Some cases may also present with proctitis. Symptoms of mpox may closely resemble other diseases such as syphilis, herpes, chickenpox, scabies, molluscum, or other skin infections. It is important to take a travel and sexual history from patients presenting with these symptoms and ask about travel history in partners.
- Call ahead to the laboratory to let them know if you are sending samples for mpox testing and contact the NT CDC to notify.
- Vaccines are available to protect against mpox and can be easily accessed from Clinic 34 sexual health clinics across the NT. For more information visit ATAGI Clinical Guidance on the use of vaccines for the prevention of mpox
- The Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) have compiled information and resources for mpox, including education resources, webinars, clinical management tools and important links. Visit Mpox Resource Directory | ASHM Health

## Extensively drug-resistant (XDR) gonorrhoea detected

- A case of XDR gonorrhoea was detected in the NT in the Top End in May 2025 – the case was locally acquired with unknown source of infection.
- XDR gonorrhoea is characterised by resistance to both ceftriaxone and azithromycin, which are routinely used to treat gonococcal infections. Cases of multidrug-resistant (MDR) and XDR gonorrhoea have been increasing globally, with XDR cases emerging especially in South-East Asia.
- Almost 700 notifications of gonococcal infection have been reported in the NT in 2025 to-date. In recent years numbers of annual cases have been increasing.
- Take travel history as part of your assessment for patients presenting for an STI screen. Overseas travel, particularly to South-East Asia, may raise your suspicion for MDR or XDR gonorrhoea.
- **Collect a swab for culture from the relevant sites for symptomatic patients before starting treatment.** PCR methods cannot detect MDR or XDR profiles – culture is required to do this. For anyone with symptoms it is important to take a swab from the exposed sites/discharge for culture before starting treatment.
- Opportunistically check for other sexually transmitted infections.
- **Perform test-of-cure (TOC) 2 weeks after treatment**. This is very important for all gonococcal infections to ensure that patients have been adequately treated, and especially important for eliminating MDR and XDR infections. A PCR swab at each site of infection 2 weeks after treatment is recommended for TOC.
- Remind patients to avoid unprotected sexual contact for 7 days after treatment is started, or until the treatment is completed and symptoms resolved, whichever is later, and to not have sex with the partner from the last 2 months until partner have been tested and treated if necessary.

**This update was prepared by Anthony Draper (Senior Epidemiologist, Surveillance and Response Unit) and NT CDC staff. We encourage NT health staff to circulate this to their clinical colleagues.**

**Contact:** View all CDC units NT wide at the NT Health website.

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