KAMS Diphtheria Guidance

1. Policy Statement

Staff should refer to the WA diphtheria outbreak case and contact management interim guidance and CDNA Interim guidance for diphtheria outbreak management for the most current principles and actions regarding case definitions. The state and national guidance outlines the key response actions and principles for interventions during diphtheria outbreaks to ensure consistency in identifying confirmed, probable, and suspected case. The KAMS document includes guidance on internal management that aligns with Kimberley Population Health Unit advice, and State and CDNA guidelines.

Certain criteria within this document is subject to change depending on the outbreak level. Please routinely check for updates and avoid printing.

Key update section 25/8/26

Case clearance

- Recommendation that where possible, respiratory positive diphtheria cases receive two clearance throat swabs via MCS taken 24 hours after completion of antibiotics, 24 hours apart

Contact management

- Re-classification of high and low risk contacts
- Recommendation that all high risk contacts receive a throat swab

Follow up

- Recommendation that all positive diphtheria cases are recalled for follow up at 2 weeks, 1 month and 3 months to monitor for complications

2. Procedures

The following sections outline the process of management of Diphtheria cases and contacts.

Notification Processes **3**
Management of Suspected and Confirmed Cases **3**
Documentation for tracking **5**
Testing **6**
Treatment **7**
Transfer out of Community **9**
Clearance of Cases **9**
Follow up **10**
Contact tracing **10**
Management of Contacts **12**
Vaccination of the Community **13**
Vaccinator Parameters **13**
Outbreak Support **14**
Definitions 14
Roles and Responsibilities 15
Related Documents 16
Additional Resources 16
References 17
Appendix 1 – Contact tracing sheet **18**
Appendix 2 – dTpa Vaccination Cheat Sheet **19**

Notification Processes

Notifications of new cases will come through the Kimberley Population Health Unit (KPHU).

- KPHU will notify the relevant **Clinic Manager** and **Infection Prevention and Control personnel**.
- Staff receiving the notification from KPHU must notify via email:
    - Medical Director
    - Remotes Executive Manager
    - Senior Medical Officer
    - Public Health Registrar

Management of Suspected and Confirmed Cases

Staff caring for suspected or confirmed cases of diphtheria should adhere to standard, contact and droplet precautions until 72 hours of antibiotic treatment completed. This includes donning PPE for close contact and wound care, including wearing:

- Gloves
- Gowns
- Surgical mask
- Eyewear

Additionally:

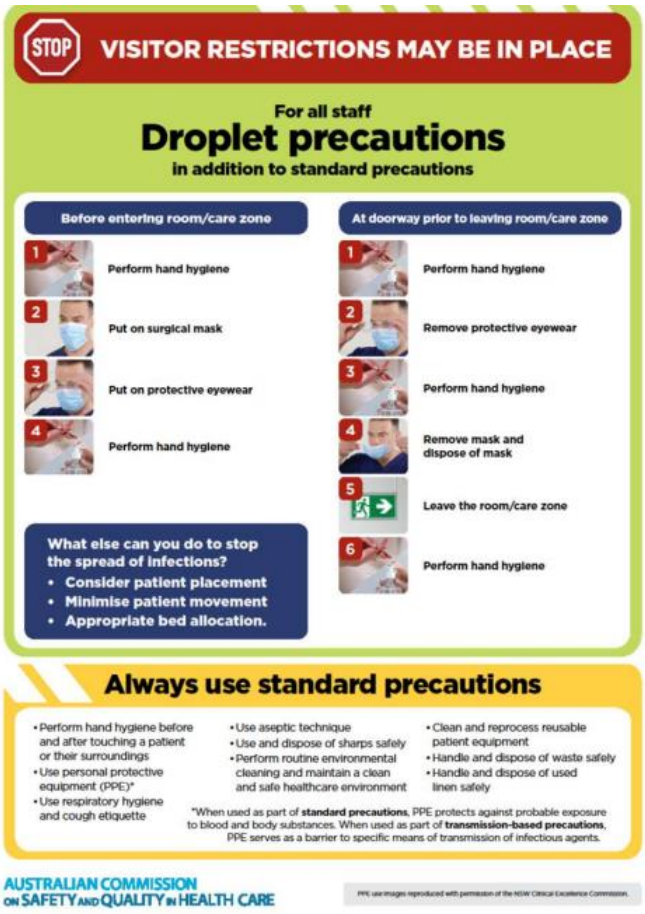
- For patients with cutaneous diphtheria ensure wounds are covered with waterproof, occlusive dressing.
- For all patients presenting to the clinic with suspected or confirmed diphtheria, ask them to wear a surgical mask.
- All cases should be advised to avoid contact where possible with people beyond their household at least for the duration of their antibiotic course.
- Provide all confirmed and suspected cases with a Factsheet.
- Utilise isolation room.

For further guidance on PPE and Cleaning refer to: DOC_2147 KAMS Standard and Transmission Based Precaution Guideline.

For signage: Standard and Transmission Based Precautions Signage.

Complete Contact Tracing and Treatment Protocol for each case as detailed below.


STOP
VISITOR RESTRICTIONS MAY BE IN PLACE
For all staff
Contact precautions
in addition to standard precautions
Before entering room/care zone
1
Perform hand hygiene
2
Put on a gown
3
Wear gloves, in accordance with standard precautions
What else can you do to stop the spread of infections?
• Always change gloves and perform hand hygiene between different care activities and when gloves become soiled to prevent cross contamination of body sites
• Consider patient placement
• Minimise patient movement
At doorway prior to leaving room/care zone
1
Remove and dispose of gloves if worn
2
Perform hand hygiene
3
Remove and dispose of gown
4
Leave the room/care zone
5
Perform hand hygiene
Always use standard precautions
• Perform hand hygiene before and after touching a patient or their surroundings
• Use personal protective equipment (PPE)*
• Use respiratory hygiene and cough etiquette
• Use aseptic technique
• Use and dispose of sharps safely
• Perform routine environmental cleaning and maintain a clean and safe healthcare environment
• Clean and reprocess reusable patient equipment
• Handle and dispose of waste safely
• Handle and dispose of used linen safely
* When used as part of standard precautions, PPE protects against probable exposure to blood and body substances. When used as part of transmission-based precautions, PPE serves as a barrier to specific means of transmission of infectious agents.
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE
PPE use images reproduced with permission of the NSW Clinical Excellence Commission.


STOP
VISITOR RESTRICTIONS MAY BE IN PLACE
For all staff
Droplet precautions
in addition to standard precautions
Before entering room/care zone
1
Perform hand hygiene
2
Put on surgical mask
3
Put on protective eyewear
4
Perform hand hygiene
What else can you do to stop the spread of infections?
• Consider patient placement
• Minimise patient movement
• Appropriate bed allocation.
At doorway prior to leaving room/care zone
1
Perform hand hygiene
2
Remove protective eyewear
3
Perform hand hygiene
4
Remove mask and dispose of mask
5
Leave the room/care zone
6
Perform hand hygiene
Always use standard precautions
• Perform hand hygiene before and after touching a patient or their surroundings
• Use personal protective equipment (PPE)*
• Use respiratory hygiene and cough etiquette
• Use aseptic technique
• Use and dispose of sharps safely
• Perform routine environmental cleaning and maintain a clean and safe healthcare environment
• Clean and reprocess reusable patient equipment
• Handle and dispose of waste safely
• Handle and dispose of used linen safely
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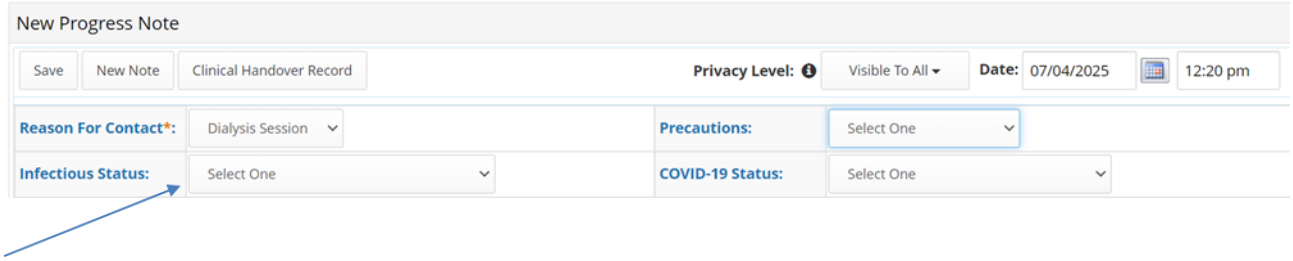
Documentation for tracking

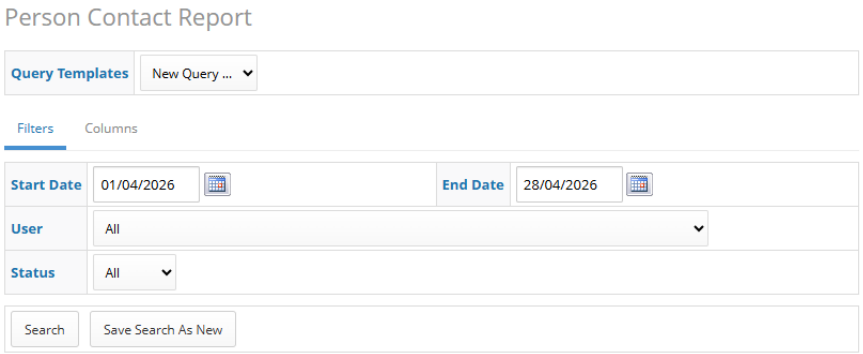
Ensure the patient has been documented as a ‘Diphtheria’ or ‘Diphtheria close contact’ case using the Infectious Status drop down in progress notes. This allows for MMEx reports on current cases and close contacts.

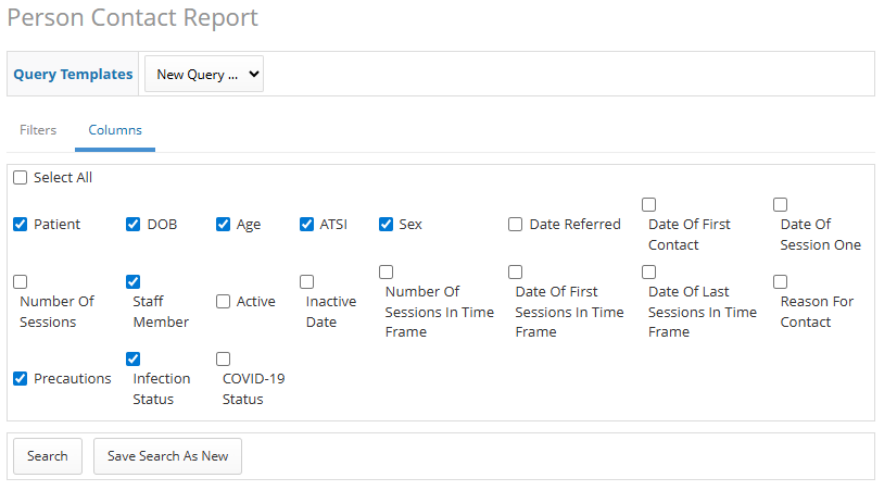


To run a report on the flagged cases:

1. Navigate to Forms and Reports
2. Click ‘Person Contact via Progress Notes’
3. In ‘Filters’ sections ensure under ‘Users’ that ‘All’ is selected
4. Enter in relevant dates
5. Select ‘Columns’
6. Unselect categories not required for report
7. Click search
8. Export to excel for data cleaning

Example:





Testing

- Suspect respiratory diphtheria in cases of exudative tonsillitis, or those who are very unwell with fever, enlarged cervical lymph nodes and upper respiratory tract infection symptoms.
    - For those with respiratory symptoms, also take POCT for Strep A
- Suspect cutaneous diphtheria in cases with slow healing or non-healing wounds, or wounds that appear punched out with a blue/grey tinge.
- **Alert the senior GP before testing for diphtheria – antibiotics should be commenced for symptomatic patients prior to receiving results.**

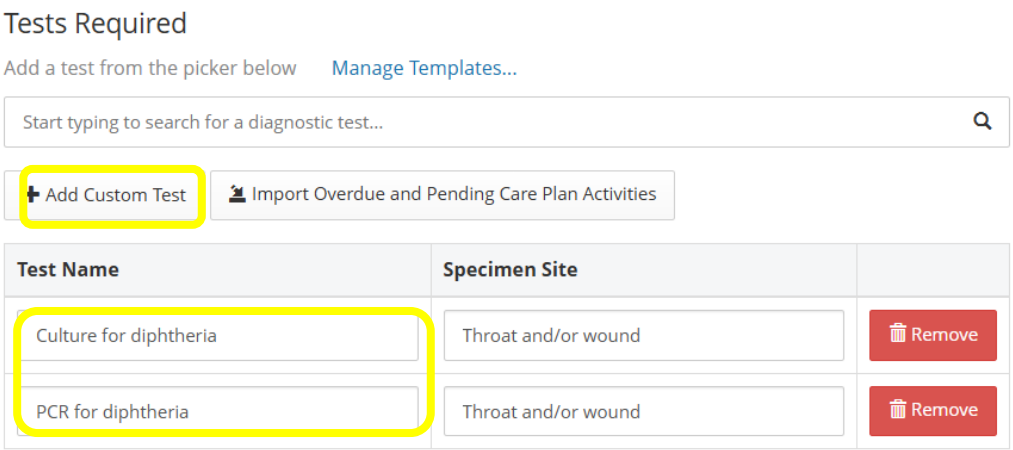
Swabs

- Two swabs need to be collected for throat and/or wound swabs (see below)
    - 1. Semi-solid transport medium swab (Amise) with or without charcoal (black top) for **diphtheria culture**
    - 2. Paired PCR dry swab (orange top) for **direct PCR toxin testing**
- If you suspect cutaneous diphtheria you must ALSO take a throat swab for diphtheria.
- Ensure you **free text 'culture and PCR for diphtheria'** on the pathology request form.
- The results will return in 2 stages: the PCR result will show presence of diphtheria toxin gene; the second MC+S result will show growth of *C Diphtheriae* or *C Ulcerans* bacteria.
- If you need to order additional supplies of dry or charcoal swabs, please order directly through PathWest's Clinic Supply Order Form.

Charcoal swab

Dry swab

Request should look like:



Treatment

There are two pathways for **toxigenic positive diphtheria** treatment, based on type of infection (respiratory versus cutaneous). Treatment of confirmed cases and contacts is in accordance with the WA diphtheria outbreak case and contact management interim guidance and e-Therapeutic Guidelines. Treatment of **toxigenic negative diphtheria** is also included below.

Confirmed Respiratory Diphtheria Toxigenic Positive

If you are suspecting respiratory diphtheria in a symptomatic patient, commence antibiotic treatment EARLY. Do not wait for the results of the swabs as there can be a delay.

Respiratory Diphtheria Toxigenic POSITIVE	
Alert	▪ Alert the Senior GP on-call for management guidance for all respiratory diphtheria ▪ Issue URGENT patient recall
Treatment	▪ If the patient is clinically **stable** and can safely swallow, prescribe: PO Azithromycin 500mg (child: 10mg/kg up to 500mg) once daily for 7 days ▪ The standard multi-day regime is strongly recommended, however a single high-dose of azithromycin may be considered if there are significant barriers to adherence to oral therapy: o Single high-dose oral azithromycin 2g (child: 30mg/kg up to 2g) ▪ If there are contraindications to azithromycin, consider alternative treatment options as per eTG – Diphtheria or discuss with an infectious diseases physician or clinical microbiologist. o E.g. amoxicillin 1g (30mg/kg up to 1g in children) orally, 8 hourly, for 14 days ▪ Ensure appropriate treatment of other organisms consistent with the clinical presentation (e.g. streptococcal throat infections) ▪ If the patient is clinically **unstable** or at risk of airway compromise (significant neck swelling, presence of a pseudomembrane in the throat, difficulty breathing, signs of sepsis), they will require transfer out of community for respiratory support and consideration of Diphtheria Anti-Toxin (DAT) Commence IV Benzylpenicillin 1.2g (child: 50mg/kg up to 1.2g) 6 hourly + IV Azithromycin 500mg (child: 10mg/kg up to 500mg) daily ▪ All severe cases also require an ECG, IV lines, Chem 8/CG4+, blood cultures and baseline neurological and cranial nerve examination.
Contact tracing	▪ Begin contact tracing for all contacts in **previous 72 hours before symptom onset** for all confirmed diphtheria on MC+S swab. Do not wait for toxigenic report as this will delay contact tracing. See *Contact tracing* page 8-10.
Follow-up	▪ If the patient remains in community, **provide daily clinical check-in**, either via home visit or telephone.
Isolation and clearance	▪ Cases should be **excluded from work, school and childcare** until they have completed antibiotics.

	▪ Where possible, clearance testing of respiratory cases with two throat MC+S and PCR swabs should be taken 24 hours after completion of antibiotics and 24 hours apart (or at least 5 days after receiving single high-dose azithromycin). o it is recognised that this may be difficult in an outbreak setting. In this circumstance, cases who attend high-risk settings (e.g. school, childcare, healthcare workers, prisons) should be prioritised o if microbiological clearance by negative throat culture is not achieved (where performed), consult with an infectious disease physician or clinical microbiologist for advice about further antibiotics. ▪ **Cases should be advised to stay at home and minimise contact with the community until demonstrated clearance of infection by two negative throat swabs collected at least 24 hours after antibiotic completion and 24 hours apart, or completion of antibiotics if swabbing is not performed.**
Vaccination	▪ Give a booster dose of dTpa if **greater than 12 months** since last dose when case is recovering from acute illness. Liaise with the Senior GP regarding timing of this.

Confirmed Cutaneous Diphtheria Toxigenic Positive

If you are suspecting cutaneous diphtheria in a symptomatic patient, commence antibiotic treatment EARLY. Do not wait for the results of the swabs as there can be a delay.

Cutaneous Diphtheria Toxigenic POSITIVE	
Alert	▪ Alert the Senior GP on-call for management guidance for all cutaneous diphtheria ▪ Issue URGENT patient recall
Treatment	▪ Cover would with occlusive water proof dressing ▪ Prescribe ▪ PO Azithromycin 500mg (child: 10mg/kg up to 500mg) once daily for 7 days ▪ The standard multi-day regime is strongly recommended, however a single high-dose of azithromycin may be considered if there are significant barriers to adherence to oral therapy: o Single high-dose oral azithromycin 2g (child: 30mg/kg up to 2g) ▪ If there are contraindications to azithromycin, consider alternative treatment options as per eTG – Diphtheria or discuss with an infectious diseases physician or clinical microbiologist. o E.g. amoxicillin 1g (30mg/kg up to 1g in children) orally, 8 hourly, for 14 days ▪ Ensure appropriate treatment of other organisms consistent with the clinical presentation (e.g. identified on wound swabs - *Staphylococcus* and *Streptococcus* are frequently co-isolated)

Contact tracing	▪ Begin contact tracing for all contacts in **previous 72 hours of symptom onset** for all confirmed diphtheria on MC+S swab. Do not wait for toxigenic report as this will delay contact tracing. See *Contact tracing* page 8-10.
Follow-up	▪ If the patient remains in community, **provide regular clinical check-in**, either via home visit or telephone.
Isolation and clearance	▪ Cases should be **excluded from work, school and childcare** until they have completed 72 hours of antibiotics OR a negative throat swab (to exclude respiratory colonization) AND the wound can be appropriately covered or is scabbed over. ▪ Clearance testing is not required for cutaneous diphtheria
Vaccination	▪ Give a booster dose of dTpa if **greater than 12 months** since last dose when case is recovering from acute illness. Liaise with the Senior GP regarding timing of this.

Diphtheria toxigenic NEGATIVE (respiratory and cutaneous)

If the diphtheria culture returns toxigenic NEGATIVE, antibiotics can be ceased, contact tracing can be ceased and no further case management or isolation is required.

Transfer out of Community

Follow usual protocols for transfer out of community based on acuity. Severe Diphtheria will need transfer to Broome Regional Hospital for anti-tox medication.

- If the patient is clinically unstable or at risk of airway compromise (significant neck swelling, presence of a pseudomembrane in the throat, difficulty breathing, signs of sepsis), they will require transfer out of community for respiratory support and consideration of Diphtheria Anti-Toxin (DAT)
    - Whilst awaiting transfer commence IV Benzylpenicillin 1.2g (child: 50mg/kg up to 1.2g) 6 hourly + IV Azithromycin 500mg (child: 10mg/kg up to 500mg) daily

ETS Script

Ensure that the ETS script includes context that the Kimberley region is currently experiencing a diphtheria outbreak and that if there is clinical or epidemiological suspicion of diphtheria, the closest anti-tox medication is at Broome Regional Hospital.

Clearance of Cases

Where possible, mild cases should undergo clearance testing with at two negative throat MCS swabs taken at least 24 hours after completing antibiotics and 24 hours apart (or at least 5 days after receiving single high dose azithromycin):

- it is recognised that this may be difficult in an outbreak setting. In this circumstance, cases who attend high-risk settings (e.g. school, childcare, healthcare workers, prisons) should be prioritised
- if microbiological clearance by negative throat culture is not achieved (where performed), consult with an infectious disease physician or clinical microbiologist for advice about further antibiotics.

- **Cases should be advised to stay at home and minimise contact with the community until clearance testing is complete or until antibiotic treatment is complete if clearance testing is not performed.**

Follow up

- Positive diphtheria cases should be recalled for follow up at 2 weeks, 1 month and 3 months to monitor for complications of diphtheria including myocarditis, peripheral neuropathy and renal injury

Time interval	Recommended follow-up
2 weeks after symptom onset	Check for symptoms of myocarditis, perform ECG if symptomatic Perform clearance swabs for respiratory diphtheria if not already done Provide diphtheria booster vaccination if due
1 and 3 months after symptom onset	Assess for signs or symptoms of neuropathy Consider UEC, particularly in those with renal disease

Contact tracing

- Wait for advice from KPHU confirming a toxigenic positive diphtheria case before commencing contact tracing and treatment.
- Take a contact tracing history from the patient and/or guardian for all contacts in the last 7 days.
- Attend the positive cases home to take a contact tracing history.
  This helps prevent spread in the clinic and can give an idea of household contacts.
- Each contact will be classified as HIGH, MEDIUM or LOW risk, depending on their exposure. Please see Table 1.
    - The risk category will determine the management.
- Please use the KPHU form emailed to clinics to document contact tracing
- All spreadsheets must be sent to IPC+C (emma.martinskis@kamsc.org.au) who will forward onto KPHU
- See Appendix 3 for AHCWA patient facing resources for contact tracing.

Table 1: Close contact risk stratification.

Risk category	Contact Tracing Criteria **Respiratory**	Contact Tracing Criteria **Cutaneous**
HIGH	Household contact: Those who have spent most of a day (8 hours), overnight or multiple days during the infectious period in the same house (or dormitory type room) and had direct interaction with a case. Including intimate partners and travel companions during the	Household contacts: Those who have spent most of a day (8 hours), overnight or multiple days during the infectious period in the same house (or dormitory type room) and had direct interaction with a case, including intimate partners. Those who had close physical contact or had direct contact with skin lesions or exudate,

	infectious period. Healthcare workers: direct unprotected exposure to respiratory secretions (swabbing or examining throat without PPE, resuscitation). Childcare and school: Those who are known to have direct interaction with a case for example two full childcare or school days (where one full day is 6-8 hours) or a cumulative of ≥20 hours within a 7-day window in the same group as the case during their infectious period.	dressings or contaminated items (e.g. towels, clothing, bedding) of a case Healthcare workers: Direct exposure to infected wound without appropriate PPE (e.g. wound irrigation generating droplets) Childcare and school: direct contact with a case's uncovered wound
LOW	Shared residential settings: stayed in same residential setting but did not have direct interaction with case. Childcare and school: Those who are known to have interacted with a case for <20 hours cumulative within a 7-day window during the case's infectious period (e.g. workplace, sporting event or casual social gathering) Healthcare workers: no exposure to respiratory droplets nor direct contact with respiratory secretions.	Casual or indirect contact (e.g. same school or workplace without close exposure) Healthcare workers no direct exposure to skin lesions or wound droplets.

Management of Contacts

Repeat exposure: is a contact is re-exposed to a confirmed toxigenic positive diphtheria while receiving (or within 3 days of completing) azithromycin chemoprophylaxis, no additional course is required. Re-exposure after this period requires re-assessment of risk.

HIGH Risk Contacts

- Take a **throat swab from all close contacts +/- cutaneous swab if lesions are present**.
  - Specify 'diphtheria culture' and 'diphtheria close contact' on the pathology form
- Offer a diphtheria containing **vaccination** (Boostrix, Adacel) if the contact has not had one in the last 12 months
  - If contact has not completed primary vaccination course: commence or complete primary / catch-up course.
- Symptomatic contacts: give PO Azithromycin 500mg (child: 10mg/kg up to 500mg), once daily, for 7 days as **presumed treatment**.
- Asymptomatic contacts: give PO Azithromycin 500mg (child: 10mg/kg up to 500mg), once daily, for 5 days as **prophylactic antibiotics.**
- The standard multi-day regimen of azithromycin is strongly recommended, however a single high-dose azithromycin may be considered where there are significant barriers to adherence to oral antibiotics: azithromycin 2g orally as a single dose (child: 30mg/kg up to 2g)
- If there are contraindications to azithromycin, consider alternative treatment options as per eTG – Diphtheria or discuss with an infectious diseases physician or clinical microbiologist.
  - E.g. amoxicillin 1g (30mg/kg up to 1g in children) orally, 8 hourly, for 14 days
- Where possible, avoid contact with vulnerable populations (e.g. elderly, immunocompromised, young infants until completion of 72 hours of antibiotics or when returned a negative test.
- Advise to monitor for symptoms for 7 days.

LOW Risk Contacts

- Advise to monitor for symptoms for 7 days.
- Test if symptomatic
- Offer a diphtheria containing **vaccination** (Boostrix, Adacel) if the contact has not had one in the last 5 years
  - If contact has not completed primary vaccination course: commence or complete primary / catch-up course.

Vaccination of the Community

Vaccination criteria is subject to change depending on the outbreak level. Please routinely check for updates to this section via LogiQC Doc_4375.

Main points:	• Opportunistically offer vaccination check to any community member attending the clinic. • Encourage cases or close contacts to talk to people about the vaccine and attend the clinic to check their status if they are worried. • Use **Boostrix or Adacel** for vaccination to cover for pertussis booster.
Community	• Offer booster dTpa vaccine if 5 years or more since last dose for Aboriginal adult patients • Actively recall any patient who has not completed primary course or is due a dTpa vaccine as per the WA Health Immunisation Schedule
Cases	• Vaccinate with dTpa vaccine if 1 year or more since last dose once starting to recover from acute infection
Close contacts	• Vaccinate high risk and medium risk close contacts if it has been over 1 year since last dTpa vaccine
Health care workers	• Recommend booster dTpa vaccine if 5 years or more since last dose *as per WA Health Immunisation Schedule update 30 April 2026*
Non-Aboriginal patients	• Non-Aboriginal patients living in the Kimberley are eligible for a booster dTpa vaccine if 5 years or more since last dose as *per WA Health Immunisation Schedule update 30 April 2026* • Eligible for free vaccine if HCW or pregnant or have not completed primary course as per WA Health Immunisation Schedule

Vaccinator Parameters

For Nurses, Midwives, AHPs, AHWs to maintain practice within the immunisation SASA – any vaccine given outside of the current WA Immunisation Schedule should be prescribed by a member of the medical team. **Contact an onsite or on-call GP for prescribing a diphtheria containing vaccine if not within WA Immunisation Schedule criteria.**

Vaccine Competency

All staff providing vaccinations should be up to date with the 2026 Vaccine Update and Cold Chain training on the WA Health Rise platform to meet criteria for administering the dTpa vaccines under a SASA if this becomes available.

Link to training: https://immunisation-education.reach360.com/learn/my-learning

Vaccine Ordering

Ensure adequate stock of Boostrix and Adacel at clinic level, aim for 50 vaccinations.
Vaccination Clinicians will be contacting clinics to keep current stock levels updated to ensure rapid re-stocking available if required.

Outbreak Support

KAMS has stood up an Outbreak Management Team (OMT) in response to the outbreak.

- If you require resources or clinical support, please reach out to the Public Health Registrar at carla.deangelis@kamsc.org.au
- If you require support with vaccines, please email vaccinesupport@kamsc.org.au
- If you require support with, or urgent extra medication, please contact KPS pharmacy
- If you require support with IP&C advice and support please contact IP&C Coordinator at infectioncontrol@kamsc.org.au
- After hours Public Health Physician - 1800 434 122
  Any cases on the weekend will be called through from the on-call Public Health Physician. Call back this number if you need to return a call.

Additionally, KPHU has designated a Public Health Nurse to coordinate the response for the Kimberley region. Their contact details:

Marama Haenga Regional Immunisation Coordinator
T: (08) 9194 1640 | **M**: 0488 255 596 | **Confidential Fax**: (08) 9194 1631
E: marama.haenga@health.wa.gov.au

Definitions

Enter definitions of terms used in this document to help give the reader context.

TERM	DEFINITION
Case	A person with laboratory confirmed toxigenic positive diphtheria.
Contact	In this scenario, a contact is a person who has had contact with a confirmed case within their infectious period.
Diphtheria	A highly contagious, and potentially life-threatening, bacterial disease caused by *Corynebacterium diphtheria* or *Corynebacterium ulcerans*. Diphtheria usually affects a person's nose, throat, and windpipe, but it can also infect their skin. The skin infection is not generally severe, but the bacteria can spread to others and may cause the more severe respiratory

	form of illness. Toxigenic positive diphtheria releases a toxin that causes widespread inflammation in the body.
dTpa	Diphtheria, tetanus, pertussis – referring to combination vaccine.
Personal Protective Equipment (PPE)	Equipment which is intended to be worn or used by healthcare workers to promote patient and personal safety against infection risks e.g. gloves / aprons / eye protection / mask.
SASA	Structured Administration and Supply Arrangement – a legal agreement that allows non-medication endorsed Nurses, Midwives, AHPs and AHWs to administer medications under strict criteria.
Standard Precautions	The minimum level of infection prevention practices applied in all healthcare situations, regardless of infection status.
Transmission based precautions	Additional measures used for patients known or suspected to have infectious diseases that can spread via contact, droplet, or airborne routes.

Roles and Responsibilities

All Staff
Comply with instructions included within this guidance, and with KPHU advise as arising.

Medical Director
Oversee and coordinate outbreak response.

Public Health Registrar
Support outbreak response through contract tracing oversight, clinical advice coordination for vaccines and treatment and provide education on request.

Vaccine Clinicians
Provide support with vaccination of community.

IPCC
Provide support with IP&C and staff vaccinations.

Related Documents

The following documents are required to give effect to this policy:

- Doc_2147 KAMS Standard and Transmission Based Precaution Guideline.
- Doc_2148 KAMS Infection Prevention and Control Policy
- Doc_2130 Management of Occupational Exposure to Blood and Body Fluids
- Doc_735 Staff Vaccine Preventable Diseases (VPD) Policy
- Doc_2131 Management of Health Care Workers with Infectious Diseases
- Doc_2245 Poster – Standard and Transmission Based Precautions

Additional Resources

KAMS Education

- Diphtheria PowerPoint from KAMS Public Health Registrar and Senior Medical Officer KAMS Diphtheria Review 17.4.pptx

Factsheets

- Aboriginal Health Council of Western Australia brochure
- Kimberley Population Health Unit Diphtheria factsheet

Poster for Clinic

- Kimberley Population Health Unit Diphtheria Poster

Australian Communicable Disease Centre

- National Notifiable Disease Surveillance System
  National case numbers and demographic information
- Epidemiology report
- Interim Diphtheria Guideline

WA Health
Case numbers by region

- Western Australia Notifiable Infectious Disease Dashboard
- WA diphtheria outbreak case and contact management interim guidance

Vaccination Resources

- Western Australian Immunisation Schedule
- WA Health Annual Vaccine Training Modules

SASAs

- WA Health SASA Nurse Vaccinators
- WA Health SASA AHPs Vaccinators
- KAMS Diphtheria SASA TBA

AHCWA Resources for Contact Tracing

- https://www.ahcwa.org.au/wp-content/uploads/2026/03/Information-for-High_Med_Low-Risk-Contacts-of-Diphtheria.pdf
- https://www.ahcwa.org.au/2026/03/06/diphtheria/

References

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2. Australian Centre for Disease Control. CDNA Interim guidance for diphtheria outbreak. April 2026. Accessed 27/04/2026 from https://www.cdc.gov.au/sites/default/files/2026-04/cdna-interim-guidance-for-diphtheria-outbreak-management_1.pdf

3. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. – version 2. Preventing and Controlling Infections Standard. Sydney: ACSQHC; 2021.

4. Australian Commission on Safety and Quality in Health Care. Standard and transmission-based precautions posters. Accessed on 05/03/25 from https://www.safetyandquality.gov.au/our-work/infection-prevention-and-control/standard-and-transmission-based-precaution-posters

5. National Health and Medical Research Council (2019) Australian Guidelines for the Prevention and Control of Infection in Healthcare. Canberra: Commonwealth of Australia.

6. The Royal Australian College of General Practitioners. Infection prevention and control standards for general practices and other office-based and community-based practices. 5th ed. East Melbourne, Victoria: RACGP; 2024.

7. Therapeutic Guidelines (2026): Pharyngeal Diphtheria. Melbourne. Retrieved 27/04/2026 at https://app.tg.org.au/viewTopic?etgAccess=true&guidelinePage=Antibiotic&topicfile=bartonella-infections&guidelinename=auto&sectionId=c_ABG_Pharyngeal-diphtheria_topic_7#c_ABG_Pharyngeal-diphtheria_topic_7

8. Western Australia Department of Health . WA diphtheria outbreak case and contact management interim guidance. Accessed on 29/04/2026 from https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Infectious-disease/diphtheria/WA-diphtheria-outbreak-case-and-contact-management-interim-guidance.pdf

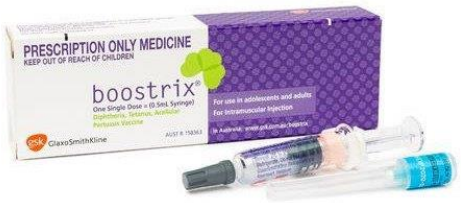
9. Australian Centre for Disease Control, Diphtheria SoNG, CDNA, published 21 August 2026 https://www.cdc.gov.au/resources/collections/diphtheria-cdna-national-guidelines-collection

Appendix 1 – Contact tracing sheet

Please use only if live spreadsheet not accessible.

Index Case Details **Name:** **DOB:**					**Diphtheria Type:**			**Toxigenic:**		**Date of contact tracing:**		
Date of contact	Address (if compound specify house number)	First Name	Surname	DOB	Risk cat: High Medium Low	Swabbed: Yes No Refused	Antibiotic type, dose duration	Vaccine name Yes No Refused	Batch Number	Factsheet Yes No	Vaccinators Name	Last diphtheria containing vaccine

Appendix 2 – dTpa Vaccination Cheat Sheet

Brand	Age group	
Adacel	≥10 years of age as booster	
ADT	≥ 5 years of age as booster	
Boostrix	≥ 4 years of age as booster Pregnancy	
Infanrix hexa	Infants and children ≥ 6 weeks of age primary immunization Booster dose in children ≥ 18 months