



Travel Medicine News

Report from the Asia Pacific Conference on Travel Health, Bali, Indonesia, July 21-23, 2000



Travel Medicine in the Developing World

“In the 21st century, developing countries will have to provide health services for travelers that are commensurate with their five-star hotels in order to maintain thriving tourist industries,” said the Indonesian Ministers of Health and Tourism at the 3rd meeting of the Asia Pacific Conference on Travel Health held in Bali, Indonesia, July 21-23, 2000. The previous two meetings were held in Hong Kong and Taipei.

Several speakers from Indonesia proposed that their government improve healthcare for visitors by establishing offices for tourist health at either the federal

or provincial government level and/or establishing licensing and accreditation systems for those providing the services. Although somewhat controversial, many international experts believe that using government resources, even in poor countries, to improve the health care of tourists – even while most local people receive only rudimentary healthcare – is an important basic step in improving the health infrastructure for the entire population. Basic goals are dependable electricity, clean water, sanitary food handling, and proper sewage disposal. (In recent years, officials in Jamaica and Tunisia, for example, asked international experts to investigate unusually high incidences of travelers’ diarrhea in these countries. The recommendations of the experts were implemented and the incidence of travelers’ diarrhea decreased, helping tourism, and also helping these countries to improve all of their sanitary services, and helping their economies.)

Continued on page 3

Report about WHO publication “International Travel and Health”

WHO is undertaking an in-depth revision of the publication “International Travel and Health” to take into account the changing trends in international travel and new health risks for travelers. The upcoming version will aim to meet the needs of all types of travelers as well as their health advisers. The information will be presented in a practical, readily accessible format and style. There are also plans to develop a web version in parallel with the book. The new version of the book is expected to be published early in 2002. The revision will be made on the basis of widespread consultation with travel medicine experts and with all the people who presently consult “International Travel and Health.” Members of the International Society of Travel Medicine are invited to submit comments and suggestions to WHO. The project is being coordinated by Dr. Lindsay Martinez, who can be contacted by e-mail at: martinezl@who.int

ISTM News

Letter from ISTM president Charles Ericsson

Dear All:

I am happy to report that Hans Lobel has agreed to continue as the editor of our Clinic Directory on a permanent basis. This publication has needed a permanent head to guarantee that the rules are predictable and followed. As one of our best, if not the best membership benefit, the clinic directory deserves this level of attention. I am pleased that Hans is willing to assume this role. Hans will also continue to work closely with Robert Steffen in his role as Chair of the Industry Liaison Committee.

Because the clinic directory is so intimately involved with membership, I am also appointing Hans to the membership committee. As such, any proposed

Continued on page 2

In this issue...

Travel Medicine News	1
Report from the Asia Pacific Conference on Travel Health	1
Report about WHO publication “International Travel and Health”	1
ISTM News	1
Letter from ISTM president Charles Ericsson	1
Notes from the ISTM Secretariat	2
CISTM in Innsbruck, Austria	2
What is your Opinion?	4
Air Rage	4
Educating the Traveler	5
Clinical Topics	6
Yellow Fever	6
Q & A: Traveling Children	8
Message from the Editor	7
Announcements	8

"ISTM News," continued from page 1

changes in format, style, content, etc. should be discussed at the membership committee level and brought forward to the Executive Board as necessary by the membership committee chair, Graham Fry. In addition, Hans has excellent ideas about how to go about improving membership. I am certain the committee will be all the stronger because of his input.

Warm regards,

Charlie Ericsson
President, ISTM

Notes from the ISTM Secretariat:

Greetings from the ISTM Secretariat in Atlanta. We are busy counting your ballots, responding to your membership renewals, and making plans for CISTM7 in Innsbruck, Austria. Please note that your name and address must accompany checks and wire transfers so that you are properly credited for extending your membership. Thank you, as always, for your continued participation and support of ISTM.

If you have not received your renewal packet, please contact the ISTM secretariat.

Results of the Executive Board ballot and changes in the by-laws will be announced in Innsbruck at the ISTM Business Meeting. Every vote is important as reflected in the recent election of the President of the United States. Please return your ballot. Without court order, your votes will be hand counted, and we guarantee accuracy.

Please plan to attend the business meeting for updates on ISTM status, progress and new initiatives and an opportunity to meet the newly elected Executive Board members.

Please review your listing in the ISTM Membership Directory. If there are revisions required, please let us know. We make every attempt to accurately list your name and location.

We are preparing for the ISTM exhibit booth at CISTM7. Please make an effort to stop by for a visit. It is a wonderful

opportunity to put names with faces and, as in the past, conference T-shirts will be available.

We hope you will encourage your non-member colleagues to attend our meeting and to join our organization. For your colleagues who are interested in becoming a member please ask them to visit the booth. Everything necessary to join will be available.

As always, please do not hesitate to contact the ISTM secretariat if you have questions, problems, or suggestions.

Susan Stokes, Administrative Director
Brenda Bagwell, Administrative Assistant
email = istm@mediaone.net
telephone = 770-736-7060

CISTM in Innsbruck, Austria

Preparations are well under way for what promises to be an unforgettable meeting. You can find up-to-the-minute details – program, downloadable forms for registration, hotel reservation, and an on-line abstracts submission facility at www.istm.org.

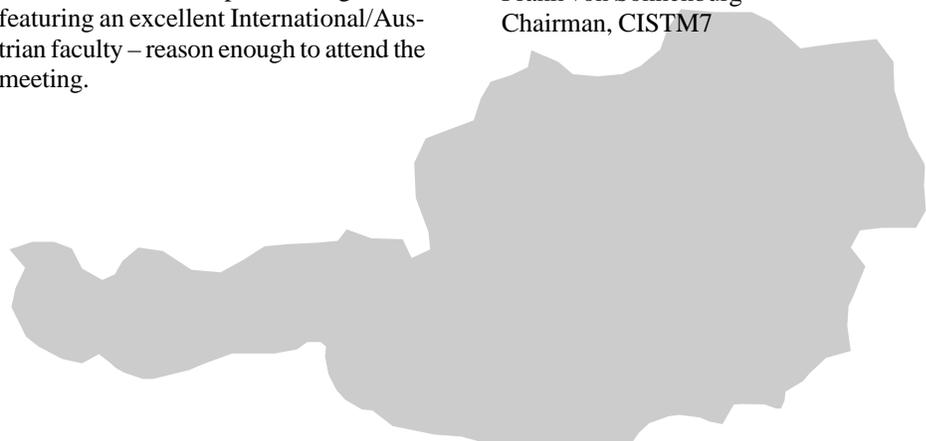
Innsbruck is a fascinating city, an old university town that is at the center of Europe. The spectacular backdrop of the surrounding mountains and a successful blend of old world charm and ultramodern technology, including one of the most modern convention center in Europe, makes Innsbruck the perfect place for both education and recreation.

Consider coming early and attending the Wilderness Medicine pre-meeting course featuring an excellent International/Austrian faculty – reason enough to attend the meeting.

We recommend that you reserve your hotel room as soon as possible and that you use the Hotel Reservation Form. Mail/fax the form to PCO Tyrol Congress. Please do not send the form to the CISTM secretariat. Note that there are no 1,000 room conventional hotels in Innsbruck but there are many hotels with 100 to 200 beds, and many smaller ones. All are excellent and charming, and accustomed to providing excellent personal services for their guests. Most of the hotels are within walking distance of the conference center. CISTM7 has reserved rooms in about 25 hotels in order to accommodate your special needs. PCO Tyrol Congress is also very experienced and will try to satisfy your requests; two winter Olympic games have been held in Innsbruck. For more information about the Congress Center, please visit, www.congress-innsbruck.at.

There are many ways to get to Innsbruck. There are direct flights from some of the major airports in Europe. Innsbruck can also be reached via Munich International Airport (MUC) which is served by most major world airlines. Good deals are often available. The airport has both train and bus service to Innsbruck and no advanced tickets are necessary. Trains leave every hour and the trip takes about 1 hour and 50 minutes. Often you arrive much earlier in Innsbruck via the Munich airport than you do by changing planes somewhere in Europe and then continuing to Innsbruck.

Frank von Sonnenburg
Chairman, CISTM7



“Travel Medicine News,” continued from page 1

However, other speakers pointed out the fact that in developing countries tourist dollars also bring problems. For example, the news – or just a rumor – that a large, luxury hotel is to be built and that there will be a need for hundreds of employees, brings many times that number of job seekers to the area. Most of the job seekers are men, and they often come from great distances. Many fail to secure jobs, stay on, and leave families behind. This creates shantytowns and causes crime and disease rates to soar. In many parts of the world the combination of tourism and local socioeconomic problems have played important roles in introducing and spreading HIV infections, for example (see below).

Today, in developing countries, the discipline of travel medicine is either in its infancy or non-existent. (The Indonesian Travel Health Society was founded in 1997, for example.) If early signs prove correct, in such countries, practitioners of travel medicine will have two important functions: caring for visitors who become ill or are injured; and, as in the developed world, preparing local people for going overseas, often to other developing countries.

The fees from visitors will be an important impetus for local physicians to modernize their clinics and to attend continuing education courses, overseas if necessary. Without such fees, overseas travel may be prohibitively expensive. And more people from developing countries are traveling internationally. For example, more than a million Indonesians already do so annually, with a large percentage of them going on pilgrimages to Saudi Arabia.

The ideal approach for keeping travelers healthy in developing countries, especially long-term travelers and expatriates, is two-pronged: travelers receive pre-travel immunizations and preventative medications from a travel medicine specialist in their home country, and then receive on-site, preventative and on-going health counseling from a travel medicine specialist in the host country, says Santanu Chatterjee, MD, consultant physician in Travel and Tropical Medicine at the

Wellesley Medicentre Calcutta, India. Ideally, the two specialists should work closely together, with the host country specialist stocking the same vaccines and completing immunization series schedules that were not completed before departure, for example. Host country physicians are in a better position to be familiar with local health risks and disease transmission patterns such as local allergens, insect precautions, and safe transport options, for example. And they can secure proper medications and arrange for consultation with other medical specialists, as well as hospitalization and evacuation, if necessary. Importantly, host country travel medicine specialists also tend to be familiar with cross-cultural adaptations and can help long-term travelers and expatriates deal with stress problems.

Names of travel medicine specialists in various countries are available from the directory of the International Society of Travel Medicine.

Members will be able to judge the caliber of colleagues by “word of mouth,” contacts at meetings, and by certification. Formal testing and other standards for the field are becoming more common.

A special event was held one day before the Conference, *A Basic Course on Travel Medicine*. Travel Medicine is a relatively new subject in Indonesia. This was the first course of its kind held in Indonesia. The aim: to help physicians new to the field to improve their basic knowledge and skills in providing health care for tourists. A short introduction was given by Professor Robert Steffen, a founder and former president of the International Society of Travel Medicine. Topics covered included *How to Set Up a Travel Clinic*, *Impact of the Environment*, *Impact on the Host Country*, *Travel Advice*, *Travelers’ Diarrhea*, *Evacuation Procedure*, *Immunization and Vaccines*. About 150 physicians participated. The course proved so successful that the Indonesian Travel Health Society (ITHS) is planning annual courses.

APTHS Business Meeting: All country representatives agreed to re-establish the

Asia Pacific Travel Health Society (APTHS) which will be the new name of APTH and consists of all countries within the Asia-Pacific Region supported by the International Society of Travel Medicine (ISTM).

The meeting elected the first executive board of APTHS:

- *President:* Prof. Dr. Yahya Kisyanto, Indonesia
- *President Elect:* Dr. Nor S. Kairullah, Malaysia
- *Secretary General:* Dr. Hanny G. Moniaga, Indonesia
- *Treasurer:* Dr. Robert Kass, Australia

The presidency term will run for two years; after this period, the President Elect will automatically be the new President and the former President will become the Past President.

The permanent office will be in Jakarta, Indonesia. The office will be run by the Secretary General who will work closely with the Treasurer. Their terms will run for 6 years.

APTHS has also elected counselors: One of their duties will be to set and maintain high scientific and professional standards for the Society.

Continued on page 4

Please Consider Joining APTHS

Obtain registration form at:

APTHS Secretariat:

Phone: 62-21-453 2202, 325 353

Fax: 62-21-453 5833, 314 4614

E-mail: hmoniaga@indo.net.id, kisyanto@dnet.net.id

The annual membership is only **US \$6.00**. Please fill in the form with capital letters and return it to the Secretariat.

“Travel Medicine News,”
continued from page 3

The Counselors elected are:

- Eli Schwartz (Israel)
- Santanu Chaterjee (India)
- Mikio Kimura (Japan)
- Xu Hua (People Republic of China)
- Abu S.M. Abdullah (Hongkong-People Republic of China)

The Society has selected Shanghai, China to be host of the 4th APTHS Conference in October, 2002, and Australia for the 5th APTHS Conference in 2004.

Some of the travel health news from the conference:

The malaria situation in Indonesia continues to deteriorate with more cases each year than the year before. The latest estimation is more than 6 million cases and about 700 deaths, with the disease appearing in areas where malaria has not been seen in decades. The reasons for the growing problems are population movements, environmental changes, drug resistance, and lack of trained personnel at the village level to perform the necessary preventative, diagnostic, and treatment functions.

The HIV/AIDS situation in China is deteriorating, the result of more international travel to and from the country, and internal migration. The number of cases is officially said to be 17,000 but the true number is probably more than 500,000. There were also large increases in drug trafficking with at least 600,000 addicted to illegal drugs, more than 4 million prostitutes, and increase in mobile population including 120 million migrant workers.

Tuberculosis is an old disease that should be kept in mind. In Indonesia, the incidence is rising annually and is now considered the most serious health challenge, with 450,000 new cases a year and 175,000 deaths. Much of the disease is multi-drug resistant. Travelers planning to spend prolonged time in the country, especially those who will have close contact with local people should have Mantoux skin tests before travel and upon returning home.

What is Your Opinion?

“What Is Your Opinion” invites comments. Please comment on items posted here. And post your items to hear what others have to say. We want a lively and timely discussion. Controversy welcomed and encouraged.



Air Rage: Does Nicotine Withdrawal Play a Role?

This term has recently been introduced to describe psychological or physical violence occurring within an aircraft. It is of particular concern for obvious reasons: the cramped conditions inside an aircraft and the inevitable involvement of not only the cabin crew but also other passengers. Passengers have had to be physically restrained from entering the flight deck. In one recent incident an apparently deranged passenger died as he was being subdued by other passengers and crew. There have been instances where aircraft have had to land prematurely to offload disruptive passengers and legal action taken against those involved.

What is air rage? There is often a developing cycle of events, which may include delays, exhaustion due to lack of sleep, excessive use of alcohol (sometimes to compensate fear of flying), minor irritations due to behavior of fellow passengers (which elsewhere would largely go

unnoticed) and sometimes anoxia causing irritability in those with pre-existing hypoxic illnesses. Not known is whether air rage is a new phenomenon or one that is receiving more publicity.

Smoking and alcohol: It has recently been recognized that there may be a relationship between air rage and nicotine withdrawal in heavy smokers on long-distance “no smoking” flights. Incidences of air rage have apparently increased as no-smoking flights have become more common; nearly all major airlines now have no-smoking policies, regardless of the length of the flights. Alcohol intoxication may also contribute. There is a small but growing groundswell to ban alcohol on flights.

Prevention: Nicotine gum or a mild tranquilizer may be useful ‘prophylaxis’ for heavy smokers on long flights. Passengers should also refrain from excessive alcohol consumption before and during flights, and discourage heavy drinking by their traveling companions. Airlines have the right to refuse to carry those who have previously caused disruption on a flight - warnings may be issued (the equivalent of yellow/red card system as used at football matches).

Announcements

(Please send us YOUR announcements. We will print as many as we can.)

Learn Tropical Medicine in the Tropics The Gorgas Course in Clinical Tropical Medicine Annual 9 week Diploma course (January 28-March 29, 2002)

For more information: Phone: 800-UAB-MIST (US) or 205 934 2687 (overseas)
Fax: 205 934 5600; E-mail: info@gorgas.org
Web: www.gorgas.org (for curriculum, photos of facilities, faculty CV's, and logistical details.)

See page 8 of this newsletter for details.

Educating The Traveler

Keeping travelers healthy, safe and comfortable is one of the missions of our Society. NewsShare intends to offer you help with this. Many travel clinic physicians tell us that after talking to clients about immunizations, diarrhea, malaria and sex precautions, there is often little time left to talk about safety and comfort, topics as important as the others but less succinct. Here is what one expert talks to his clients about and the handouts he distributes. (Please share with us what your clinic does!)

From Mark Wise in Canada

More than likely, those of us who advise travelers spend most of our time dealing with vaccine-preventable diseases, food and water-borne diseases and insect-borne diseases. Very little time is devoted to counseling travelers about the other risks, such as motor vehicle accidents and other forms of personal injury, which account for at least 25% of the mortality in international travelers. This may be due to a lack of time to spend with each traveler, and also, I believe, because most people traveling to the tropics, and many travel health professionals, perceive "exotic" infections to be their major enemy.

While we can not counsel travelers regarding every potential hazard that they may face when traveling overseas, a few minutes should be spent on two important topics:

- Common sense.
- The interrelationship between a traveler's safety and the economic, political and social conditions that prevail in the country to be visited.

While these concepts may be obvious to most of us, they are not to many travelers, even experienced ones. Common sense is by far the greatest asset when it comes to minimizing the risk of most serious accidents and death. This is not a "tropical" concept, but one that applies at home as well. Poverty, for example, is an important cause for crime, disease, and dangerous roads. Political instability results in poorly enforced laws or no laws. Also, as lesser developed countries continue to "develop," some situations will probably get worse – more vehicular traffic on poorly designed roads, and more air pollution.

It is always wise for travel medicine advisors to discuss these issues with their potential travelers and to provide some written information on the measures that can be taken to maximize one's safety



abroad. Here is what we give our clients:

Dear Traveler - The following is a list of suggestions to maximize your safety while abroad. They may not all apply to you. Travel advisory reports for each country are available from the Department of Foreign Affairs at http://voyage.dfait-maeci.gc.ca/destinations/menu_e.htm.

Your valuables:

- Make copies of your passport's identification page – carry one separately from your passport and leave one at home. Leave a copy of your itinerary, if you have one, at home.
- Keep medications in their original labeled container. If you are carrying narcotic medications, carry an explanatory note from your doctor.
- If you are carrying syringes for a medical condition, e.g. diabetes, or in the event of trauma, be sure that you have a signed, stamped, official looking letter from your doctor.
- Carry traveler's cheques, credit cards or debit cards, and only enough cash for the next day or two's activities. Make copies of all of your cards before leaving home.

- Try not to carry your passport, travel tickets, I.D., cash, credit cards, etc. all in one place.
- Carry your valuables in a waist pouch, not around your neck, ankle, neck, or in your back pocket.
- Never count your money in public.
- Keep your valuables in the hotel safe when possible.
- Change money only with authorized agents, not in dark alleys or hotel washrooms with unauthorized ones.

Rules of the road:

- Try to avoid driving in rural areas at night.
- Do not mix alcohol with driving.
- Beware of local buses – they are often overcrowded, poorly maintained, and in a great hurry. Some buses will be safer than others, though slightly more expensive.
- Avoid motorcycles if you can. Wear a helmet if you must drive one.
- At least look for a seatbelt, though you may not find one.
- Use a local driver if possible.
- There are many more things on the road in some countries – people, cows, baboons, potholes.... Drive slowly!

Your behavior:

- Never take anything, even an envelope, across a border for someone else.
- Choose your travel companions wisely. Travel in groups if possible.
- Always ask, or get some sort of implied consent, before taking pictures of local people, military installations, government buildings, etc.
- Keep your alcohol consumption down when you're out and about.

Continued on page 6

“Educating the Traveler,”
continued from page 5

- Beware of “scams” – e.g. “Excuse me. I seem to have dropped my baby on its head. Can you please bend over and get him while I check out your back pocket!” or “I’m terribly sorry I spilled that ketchup all over your dress. Perhaps you could reach into your purse for a tissue!”
- Be particularly vigilant at train and bus stations and airport check-ins.
- You probably already look like a tourist (with money). Don’t make it more obvious than it already is. Leave your jewelry at home. Dress conservatively.
- Do not walk alone and at night, in places that might not be safe (e.g. downtown, the beach).
- Do not open your hotel room door unless you absolutely know who is on the other side.
- Learn a few key phrases of the country in which you are traveling.
- Do not do drugs. You will be subject to the law of the land if you are caught.
- Take along adequate travel insurance. Read the small print.
- If you are in a “high-risk” area (e.g. working in Colombia), special measures, e.g. changing your route to work each day, should be taken. Advance planning is necessary.
- Carry a good luck charm!

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Clinical Topics

Yellow Fever

Yellow Fever is a disease of much historical significance. It is first described in early Mayan records dating from 1648. The virus most likely originated in Africa and was exported to the new world as a result of the slave trade. The term yellow fever was first used during an epidemic in Barbados in 1750.

During the eighteenth century it was recognized as

a major human disease. In the United States, major epidemics occurred in the large port cities. In 1793, it is estimated that 10% of the population of Philadelphia succumbed to yellow fever. Thomas Jefferson stated that “yellow fever will discourage the growth of great cities in our nation.” In 1802, Napoleon and 25,000 of his troops descended upon Haiti and only 3,000 survived the wrath of yellow fever. It was this event that convinced France to sell the Louisiana Territory to the United States. Napoleon felt it was a wasteland laden with disease and pestilence. The last outbreak of yellow fever in the USA occurred in New Orleans in 1905, resulting in 8,399 cases and 908 deaths.(1)

In 1881, Carlos J. Finlay, a Cuban physician, suggested that yellow fever was carried by a mosquito. In 1900, the United States, faced with annual epidemics that threatened the Mississippi valley and because the disease was seriously interfering with the construction of the Panama Canal, appointed an Army Investigative Board to study whether or not there was a mosquito/disease relationship. The Board consisted of Drs. Reed, Carrol, Agramonte and Lazear. During the course of this investigation, mostly done in Cuba, Carrol and Lazear allowed themselves to be bitten by mosquitoes which had previously fed on patients with yellow fever. Both men contracted the disease and Lazear died. In 1903 the board concluded that yellow fever was transmitted by the *Aedes aegypti* mosquito.(2) In 1927, in Africa, the virus was first identified. This led to a race for the development of a vaccine. In 1932 the French neurotropic vaccine was developed, but it was discontinued in 1982 because of cases of encephalitis followed vaccination. The 17D vaccination was developed by the Americans in 1936 and is still currently used today.

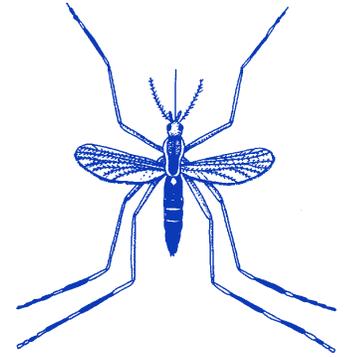
Epidemiology

Yellow Fever is now found only in Sub-Saharan Africa, the Amazonian region of South America, and occasionally in Trinidad. Africa accounts for around 90% of the cases. Yellow fever is grossly underreported due to unrecognized cases, unavailability of laboratory facilities to make the diagnosis, and poor surveillance. The WHO estimates that there are 200,000 cases a year with 30,000 deaths.(3) Yellow fever appears to be on the rise due to deforestation, urbanization, and the increases of global travel.

Life Cycle

The vector is the *Aedes aegypti* or *Haemagogus* mosquito. Vertical transmission occurs when the virus is passed on to the mosquito’s ovum. This is advantageous for continuation of the life cycle during the dry season when the eggs may lay dormant. When the rainy season returns, the eggs hatch, allowing the virus to carry on. Horizontal transmission occurs when either an animal (typically monkeys) or humans are infected by the mosquito.

There are several different transmission cycles in yellow fever: sylvatic, intermediate, and urban. All three occur in Africa, but only sylvatic and urban occur in South America.



Continued on page 7

“Clinical Topics,” continued from page 6

Sylvatic (or jungle) yellow fever occurs in tropical rainforests where monkeys are infected. Here humans are accidentally infected as a result of entering the forest. Intermediate yellow fever occurs in the humid or semi-humid savannahs of Africa where small epidemics occur in villages. Here mosquitoes infect both monkeys and humans at this zone of emergence. Urban yellow fever can occur in large epidemics where the virus is passed from human to human via the mosquito.

Pathology

Yellow Fever is the prototype of the flavivirus family. It is a small (40-60nm) single stranded RNA virus. There are several different genotypes of the virus, which vary based upon the geographic region. Lymphoid cells are the principal targets for early replication. During the viremia the Kupffer cells are seeded causing direct viral damage to the liver. The pathological findings of yellow fever in the liver are midzonal necrosis and Councilman bodies (eosinophilic intranuclear inclusions). It is not uncommon for damage also to occur to the kidneys and heart. Bleeding is the result of a hemorrhagic diathesis.

Clinical Presentation

The incubation period is usually 3 – 6 days, then symptoms of fever, malaise, headache, photophobia, nausea, vomiting, and irritability may occur. Physical examination at this time reveals a patient who is febrile, toxic in appearance and who has hyperemic skin, injected conjunctiva, coated tongue, and epigastric or hepatic tenderness. Faget’s sign may be present, a relative bradycardia with a fever. After 3 to 5 days, either the patient recovers or goes onto the next stage of fulminate disease.

In fulminate disease there is significant hepatic injury with jaundice occurring, hence the name “yellow fever.” Renal failure is not uncommon. A hemorrhagic diathesis may occur causing of epistaxis, oozing at the gums, petechiae, ecchymosis, hematemesis: (“black vomit”), melena, hematuria, thrombocytopenia, and disseminated intravascular coagulation.

Myocarditis, encephalopathy, and shock may also ensue. The case fatality rate is from 20% –50%. If one survives, a full recovery can be expected.

The differential diagnosis of yellow fever includes leptospirosis, relapsing fever, malaria, typhoid, viral hepatitis (especially hepatitis E), Q fever, and other viral hemorrhagic fevers.

Diagnosis

The diagnosis of yellow fever can be very difficult in isolated cases; when epidemics occur physicians are vigilant to the dis-

ease and the diagnosis is generally made. In the tropics, the diagnosis is often a clinical one. A liver biopsy can be done looking for the pathological changes. However, the biopsy findings are not absolute and do not exclude the possible diagnosis. Moreover, liver biopsies in yellow fever can be associated with massive hemorrhage. In developed nations there are specialized laboratories that can assist in the diagnosis. In such facilities the diagnosis can be made by viral

Continued on page 8

Message from the Editor

Hi ISTM Member:

As the new editor/webmaster for ISTM, I would like to thank all of you who have contributed to this issue and want to invite those who have not to participate in our upcoming newsletter/website postings. It will take very little of your time and effort to get involved.

We want the ISTM newsletter/website to be lively, timely, and informative, the forum of communication for the worldwide travel medicine community. Please comment on the contents of this issue/posting. And please send us news items that you would like to share with your colleagues. Here are some ideas:

- Comments on articles in the literature about your area of expertise. Several paragraphs are sufficient.
- Newspaper clipping and articles from your local medical publications of interest to the world travel medicine community.
- Announcement of meetings dealing with travel medicine and related subjects.
- Notes from your lectures.
- Short articles written by you.
- Other information of interest to our members.

Several members whose native language is other than English have said that they would contribute if their written English was better. Please do not worry about that. Travel medicine is what we are all interested in, not language skills. In fact, we are always impressed how well our non-native English speakers communicate in English. We can help you with language problems in writing – we often do that for our English speaking members, too.

The deadline for the next newsletter/website posting is February 15th. We would like to have some submissions by that date – but that is not essential. If that date is too soon for you we will use your material in future issues.

To start, we will have six issues a year. To reach me, see the masthead.

I hope to hear from many of you.

Best wishes,

Karl Neumann, MD
Editor/Webmaster

“Clinical Topics,” continued from page 7

cultures, PCR, or preferably from ELISA tests looking for the IgM rise during acute infection.(4)

Treatment and Prevention

Treatment for yellow fever is supportive in nature. Preventive measures are several fold and include vector control, surveillance, and immunization. The 17D yellow fever vaccination is the only strain available. It is a live, attenuated vaccine and has several contraindications including: children under 9 months of age, pregnancy, and immunosuppression. The vaccine can only be administered by a designated yellow fever center. The vaccination dose is 0.5 ml given SC in the upper arm. Travelers should receive the vaccination at least 10 days prior to departure for effective immunity. International regulations require a booster every 10 years to enter or depart from endemic yellow fever regions.

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Q & A: Traveling Children

At the recent American Society of Tropical Medicine and Hygiene meeting in Houston, Texas, information about controversial issues affecting children was presented by three experts in pediatric travel medicine, Sheila Mackell, Karl Neumann and John Christenson. The material they presented is useful in formulating responses to common clinical questions. The meeting was chaired by Phil Fischer, who provide this summary of some of their discussions.

1. Is mefloquine safe in children who have had a febrile seizure?

Mefloquine alters the seizure threshold. Consequently, travelers with seizure disorders are usually advised to use a prophylactic agent other than mefloquine. More than one percent of young children have simple febrile seizures (convulsions associated with fever in the absence of underlying pathology of the central nervous system) but do not go on to manifest epilepsy with a persistent risk of recurrent convulsive episodes. To date, there have not been reports of mefloquine-related seizures in individuals with histories of simple febrile seizures. Thus, mefloquine can probably be safely used in children who have had simple febrile seizures. An alternative chemoprophylactic agent would be used in children with histories of prolonged, focal, or recurrent seizures and in children who have had neurologic deficits associated with their seizures.

2. Should infants be restrained in safety seats on airplanes?

Data are limited, but anecdotal reports suggest that one serious injury or death might be prevented every 2 years by the universal in-flight use of infant restraints. Commonly used car seats, however, are not particularly designed to protect babies from the sorts of jarring forces that occur with turbulence and air crashes. Also, there is concern that the ticket cost of using airplane seats for infants in their restraints would prompt some families to travel by automobile rather than by airplane; car travel is linked to greater accident risk and death per mile than is air travel. Further study and the development of airplane-specific restraining seats can continue, and some families can use infant car seats on airplanes for the potential, yet costly, benefit they offer. Mandating universal use of infant restraints, however, is not currently appropriate.

Continued on page 9

Announcements

(Please send us YOUR announcements. We will print as many as we can.)

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Fax: 205 934 5600; E-mail: info@gorgas.org
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“Clinical Topics,”
continued from page 8

3. When antibiotic therapy is indicated for the treatment of a child with traveler’s diarrhea, which agent should be used?

The organisms causing traveler’s diarrhea seem to be the same in children as in adults, and many of those germs are resistant to cotrimoxazole (trimethoprim-sulfamethoxazole). Thus, cotrimoxazole is no longer the antimicrobial of choice for traveling children with diarrhea. Azithromycin is effective against the common pathogens, is well-tolerated, and is available in a child-friendly liquid formulation. An alternative antibiotic, ciprofloxacin, is commonly used in adults but is not approved in some countries for pediatric use due to concerns about skeletal toxicity in experimental animals. Thousands of children, however, have used ciprofloxacin for serious infectious conditions and have not experienced untoward outcomes. Ciprofloxacin can be used for traveler’s diarrhea in children, especially when other effective agents are not available.

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ISTM NewsShare

108-48 70th Road
Forest Hills, NY, USA 11375
Tel: 718-263-2072
Fax: 718-575-0290
E-mail: travhealth@aol.com

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P.O. BOX 871089
STONE MOUNTAIN, GA 30087-0028 USA
PHONE: 770-736-7060
FAX: 770-736-6732
EMAIL: ISTM@MEDIAONE.NET