



## Society News

### Certificate of Knowledge in Travel Medicine

Examination Update – March, 2002

**T**he ISTM is pleased to announce that the first international Certificate of Knowledge in Travel Medicine exam will be administered immediately prior to the opening of the 8<sup>th</sup> CISTM. The exam will be held Wednesday, May 7<sup>th</sup> 2003, at the Marriott Marquis (the conference hotel) in New York.

The 200 item multiple choice examination has been designed to assess and recognize individual excellence in knowledge in the field of travel medicine. Passing this examination will lead to a Certificate of Knowledge in Travellers' Health. Professional development and enhanced professional credibility are cited as the top two reasons people are interested in taking such an examination.

The purpose of this examination is to:

- Promote professional development.
- Enhance the quality of patient care.
- Establish internationally recognized standards of knowledge.
- Recognize, in a formal manner, individuals who meet the ISTM standards of excellence in travelers' health.

The Body of Knowledge, upon which the exam will be based, has been published on this website and will also be published in the spring of 2002 in the Journal of Travel Medicine. We will also publish a list of courses and programs with travel medicine content that examinees may find helpful while preparing for the examination. Please note that the ISTM is not sponsoring its own review course.

The Co-chairs for the Examination committee are Drs. Robert Steffen, Francesco Castelli, and Jay Keystone.

Robert Steffen is the Head of the Division of Communicable Diseases, Institute of Social and Preventive Medicine (ISPM) at the University of Zurich and the Director of the World Health Organization Collaborating Centre for Travelers' Health.

Francesco Castelli is an Associate Professor of Infectious Diseases and the Director of the Post-Graduate School of Tropical Medicine at the University of Brescia, Italy, in the Institute of Infectious and Tropical Diseases.

**Location of Exam:** The Certificate of Knowledge Examination will be administered at the Marriott Marquis hotel in New York on Wednesday, May 7, 2003. The Marriott Marquis is also the site of the 8<sup>th</sup> CISTM is being held May 7-11, 2003.

**Body of Knowledge:** The Body of Knowledge is being published in the March/April issue of the Journal of Travel Medicine. It can be found on pages 112-115. It has also been posted on the ISTM website (www.istm.org). You will find it by selecting "Educat. Postings" from the left hand menu on the home page.

**Eligibility:** The exam is open to all licensed travel medicine practitioners including nurses, physicians, pharmacists, and physician's assistants. Both ISTM members and non-members are eligible to participate.

**Acknowledgement:** The ISTM Examination Committee gratefully acknowledges GlaxoSmithKline for their generous support of this endeavour. GSK has provided an educational grant to help fund the development of the exam. Their support has enabled us to retain expert consultants to guide this project, evaluate questions, and perform a psychometric analysis of the exam. This process will ensure that this examination meets rigorous standards and is statistically valid.

*Continued on page 5*

## Shark Attacks

Paul S. Auerbach, M.D.

**A**lthough dreaded, sharks are among the most graceful and magnificent denizens of the deep, and the subject of many ongoing behavioral investigations. Sharks may be found in oceans, tropical rivers and lakes. They range in size from 10 to 15 centimeters up to the whale shark, which is more than 15 m long and weighs 18,000 kilos. The whale shark is, fortunately, a plankton feeder.

Approximately 32 out of the at least 368 species of sharks have been implicated in the 50 to 100 shark attacks (with 6 to 10 deaths) reported annually worldwide, and another 35 to 40 species are considered potentially dangerous. The danger of sharks to humans is their combination of size, aggression and dentition. Even small sharks can be powerful and destructive. The white shark ("great white" or "white pointer") is likely responsible for more attacks on humans than is any other species, especially in the waters of southern Australia, the east coast of South Africa, the middle Atlantic coast of North America, and the American Pacific coast north of Point Conception, California. The latter is a breeding area for elephant seals, which yield 90-kilo pups, perfect food for the immense predators. Tiger sharks and

*Continued on page 2*

### *In this issue..*

<b>Society News</b> .....	1
<b>Certificate of Knowledge in Travel Medicine</b> .....	1
<b>Practice and Nursing Issues Committee News</b> .....	5
<b>Health of Migrants and Refugees Committee News:</b>	
<b>The Migrant as a Traveler-Visiting Friends &amp; Relatives</b> .....	5
<b>Travel Medicine in Japan</b> .....	6
<b>"Personal Safety Advice for Travelers Abroad" Recognized</b> ..	6
<b>Shark Attacks</b> .....	1
<b>Calendar</b> .....	7

*“Shark Attacks,” continued from page 1*

*“Although most shark attacks occur within 30 meters of shore, the danger is probably greater further out, in deep channels or drop-offs.”*

bull sharks are also considered to be quite dangerous with regard to attacks upon humans. The great hammerhead has a reputation as a man-eater in equatorial waters.

Although sharks are not highly intelligent, they are endowed with remarkable sensory systems. Their color vision is poor, but well compensated for by their acute perception of motion. Keen olfactory and gustatory chemoreceptors permit taste and the recognition of blood, urine or peritoneal fluid in the water - in some cases, to a sensitivity of one part of blood in 100 million parts of water. Sharks are keenly aware of chemicals similar to those produced by normal prey, such as amino acids, amines and small fatty acids. Up to two-thirds of the shark brain may be devoted to smell. Sharks also possess skin chemoreceptors that detect chemical irritants, and are able to detect minute electrical impulses. These systems allow sharks to locate struggling fish, swimmers or divers. The common smooth dogfish shark can detect an electrical voltage gradient of 5/1000 of a microvolt. Sharks also have extremely sensitive hearing, which may detect prey underwater from a distance of up to 900 meters.

**Shark Feeding and Attack.** Sharks feed in two basic patterns: normal or subdued,

with slow, purposeful group movements; and frenzied or mob, as the result of an inciting event such as the sudden presentation of commotion or food/blood in the water. Frenzied behavior is enhanced by the proximity of other sharks in large numbers. In a frenzy, sharks become fearless and savage, snapping at anything and everything, including each other. After a shark decides to attack, it “postures”, swimming erratically with elevated snout, arched back, pectoral fin depression, stiff lateral bending of the body and rapid tail motion. In bursts of motion, a shark can use its powerful caudal fin musculature and attain speed in the water of up to 64 kilometers per hour. As a shark prepares to strike, it typically opens and closes its jaws (up to three times each second), depresses the pectoral fins in a braking action and elevates its head. During a bite, the shark shakes its head and forebody in an effort to tear flesh from the victim. The shark may “bite and spit” in order to mortally wound the victim prior to consuming it. Sharks swallow food whole without chewing it.

It is difficult to postulate hunger as the sole attack motive, since more than 70% of victims are bitten only once or twice. “Hit and run” attacks are most common. Usually, the lower teeth are used first in feeding; solitary upper-tooth slashes might indicate an attack unrelated to feeding. Up to 60% of wounds involve only the upper teeth. Sharks are selective feeders with clear dietary preferences. They commonly attack the young, old, injured and/or sick prey individuals. Sea turtles, squid, penguins, seals and stingrays are consumed in preference to man. Sharks often eat other sharks.

**Attacks on Humans.** It is very difficult to generalize about shark attacks on humans. Current explanations favor aggression directed at the frightened victim. Aggression may be aggravated by purely anomalous behavior, violation of courtship patterns or territorial invasion. More docile behavior tends to be the rule with most reef sharks. The white shark (which may reach a size of 7.6 meters and a weight of 2,500 kilos) is a man-attacker but prob-

ably not a man-eater; it usually releases its victim after a single bite, after it recognizes that a mouthful of neoprene, fiberglass or lead weights is not normal dietary fare. This is small consolation to the unfortunate victim, who may have an entire hemithorax or limb removed. In circumstances where human victims have been largely consumed, one theory is that this was because they were solitary in the water. A breath-hold diver’s behavior and the similarity in appearance of the silhouette of contemporary surfboards to that of a surface seal may be responsible for attacks upon humans. Most attacks upon humans occur at the water’s surface. However, at least one fatal attack in 1989 with two victims was upon sea kayakers off the coast of southern California.

Shark attacks have occurred from the upper Adriatic Sea to southern New Zealand, with most between latitudes 46° N and 47° S. The odds of being attacked by a shark along the North American coastline is approximately one in five million. The danger is greater during the summer months (more persons in the water), in recreational areas, during late afternoon and nighttime, and in murky warm (greater than 20° C) water. White sharks frequently venture into colder water, and attacks have occurred in water as cold as 10° C. Contrary to the trends suggested by world-wide shark attack analysis, attacks in northern California occur more frequently in clearer water at temperatures less than 16° C.

Although most attacks occur within 30 meters of shore, the danger is probably greater further out, in deep channels or drop-offs. Because of their ability to detect contrasts, sharks have a predilection to attack bright, contrasting or reflective objects. Movement is an added attraction to sharks, which have been known to bite surfboards, boats and buoys.

Most victims are attacked by single sharks, violently and without warning. In the majority of attacks, the victim does not see the shark prior to the attack. The first contact may be a bumping, which is

*Continued on page 3*

“Shark Attacks,” continued from page 2

an attempt by the shark to wound the victim prior to the definitive strike. Severe skin abrasions from the shark skin (“shagreen”) placoid scales (denticles) can be engendered in this manner.

**Clinical Aspects.** The jaws of the major carnivorous sharks are crescent-shaped and contain up to six rows of razor-sharp rip-saw triangular teeth, which are replaced every few weeks by advancing the inner rows. While normal tooth replacement takes 7 to 10 days, in some species a lost tooth can be replaced within 24 hours. The upper jaws generally have larger “cutting” teeth, while the sharp lower teeth are designed to fasten onto and hold prey as part of prey capture. The teeth are cartilaginous, strengthened by the deposition of calcium phosphate crystals (apatite) in a protein matrix, all covered by an enameloid substance. They are considered to be as hard as granite and as strong as steel. In a great white shark, the largest serrated triangular teeth can grow to a length of 6 cm with 26 upper and 24 lower teeth exposed in the front row. The upper jaw is advanced forward and protruded to allow its participation in the biting action. Severe shark bites result acutely in massive tissue loss, hemorrhage, shock and death. Even a smaller animal can bite with bone-crushing force. The potential for rapid destruction is unparalleled in the animal kingdom.

The human leg(s) is most frequently bitten, followed by the hands and arms, as the victim attempts to fend off the shark. Proximal femoral artery disruption carries a poor prognosis because of the torrential nature of hemorrhage. Fractures are not uncommon, and broken ribs are often accompanied by intrathoracic, intraperitoneal and retroperitoneal injuries. Because the victim is generally far from medical assistance, blood loss may be profound. The wounds have historically been fatal in 15 to 25% of attacks, with major causes of death listed as hemorrhage and drowning.

**Treatment.** In most cases, the immediate threat to life is hypovolemic shock. It is occasionally necessary to compress wounds or manually to occlude severed



blood vessels while the victim is in the water. As soon as the victim is out of the water, all means available must be used to ligate large, disrupted blood vessels or to apply compression dressings. Pressure point compression or tourniquets have been needed on occasion, balancing critical blood loss with the complications associated with their misuse. If intravascular volume must be replaced in large quantities, at least two large-bore intravenous lines should be inserted into the uninvolved extremities in order to deliver crystalloid (lactated Ringer’s solution, normal saline or hypertonic saline), colloid or blood products. Central venous cannulation should be reserved for the emergency department.

The victim should be kept well-oxygenated and warm while being transported to a facility equipped to handle major trauma. Blood losses should be replaced with whole blood or packed red blood cells and fresh frozen plasma. The precise ratio of crystalloid to blood products and proper mean arterial blood pressure end point of primary resuscitation in the presence of a major vascular injury are the subjects of ongoing investigations. The victim should be thoroughly examined for evidence of cervical, intrathoracic and intra-abdominal injuries. Because *Clostridium* can be cultured from ocean water, tetanus toxoid 0.5 mL IM and tetanus immune globulin must be given. The administration of prophylactic antibiotics is more controversial, and is guided by the risk for a *Vibrio* infection. The victim of a shark bite may be treated with a parenteral third generation cephalosporin, trimethoprim-sulfamethoxazole, chloramphenicol, an

aminoglycoside, ciprofloxacin, or some reasonable combination of these agents. The rationale for prophylactic antibiotics is that shark wounds are prone to heavy contamination with sea water, sand, plant debris, shark teeth and shark mouth flora. After a clinical infection is recognized, wounds should be properly cultured for aerobes. Wound cultures prior to the establishment of an infection are less useful. Marine organisms can be virulent yet difficult to identify.

Proper operative intervention is mandatory. It is inappropriate to attempt emergency department exploration of what often prove to be extensive and complicated wounds. In the operating room, devitalized tissue should be widely debrided and the wound irrigated copiously to remove all foreign material. Unless absolutely necessary, the wound should be closed loosely with drains or packed open to await delayed primary closure. Although there is debate about whether to use internal or external fixation of grossly open and contaminated fractures, it seems logical to recommend surgical stabilization to facilitate vascular and soft tissue repair. The abrasions associated with a shark bumping should be managed like a second-degree burn, with daily debridement and application of antiseptic ointment. A reasonable “shark pack” should be available in emergency facilities and rescue vehicles near shark-infested waters. This must be portable and should include items necessary to control hemorrhage and initiate IV therapy.

**Prevention.** Shark behavior can be unpre-

Continued on page 4

“Shark Attacks,” continued from page 3



dictable. There is no such thing as a “friendly” shark. Shark-infested water should be avoided, particularly at dusk and at night. This fundamental rule is disregarded amazingly often. Surfers are generally at greater risk than divers. Do not disguise yourself as a pinniped (seal). Do not swim with animals (e.g., dogs or horses) in shark waters.

Swimmers should remain in groups. Isolation creates a primary target and eliminates companion surveillance. When diving, vigilance must be constant.

Turbid water, drop-offs, deep channels, breeding inlets and sanitation waste outlets are areas frequented by larger sharks. However, it appears that sharks attack at least half the time in clear water. Humans are most often attacked in shallow water and further from shore.

Blood and other body fluids (including peritoneal fluid) attract sharks. No person should be in shark waters with an open wound. Women have occasionally been advised to avoid diving during menstruation, but this is controversial and without proof of efficacy.

Game fish are attracted to brightly colored and flashy metallic lures. Brightly colored swimwear or diving equipment and shiny snorkeling gear may attract sharks. Orange appears to be attractive to sharks. Black is a less attractive color.

Captured fish must be removed from the water or stored at a considerable distance from divers. There is no greater chemical attractant for a shark than fish blood.

The presence of porpoises in the water does not preclude the presence of sharks. Be alert for the presence of a shark whenever schools of fish behave in an erratic manner.

Never tease or corner a shark. This is particularly true with captive animals. If a shark begins to act in an erratic manner, do not photograph it at close range using a strobe flash apparatus.

If a shark appears in shallow water, swimmers should leave the water with slow, purposeful movements, facing the shark if possible and avoiding erratic behavior that could be interpreted as distress.

If a shark approaches in deep water, the diver should remain submerged, rather than wildly surface to escape. He should move to defensive terrain with posterior protection in order to fend off, as best as possible, a frontal attack. It is inadvisable to trap a shark, so that it must attack to obtain freedom.

Fighting sharks is very difficult; they are best repulsed with blunt blows to the snout, eyes or gills. If possible, the bare hand should not be used, in order to avoid severe abrasions or lacerations. A stream of air bubbles from a SCUBA regulator directed into the face of a shark may be sufficient deterrent. Although spears, knives, shotgun shell- or 30-.06 loaded powerheads, strychnine-filled spears and CO<sub>2</sub> darts can kill small sharks, they can worsen the situation if they are misapplied or their application promotes frenzy in a school of sharks.

Do not splash on the surface or create a commotion in a manner that might cause a shark to interpret your behavior as that of a struggling fish. Surface chop and perhaps the sounds created by helicopter rotors attract sharks.

Shark defense techniques and repellents are in constant evolution. Recreational beaches in Australia and South Africa are protected with extensive gill net systems to trap overly curious animals. These work to a certain degree, but are not foolproof. Electric shark barriers utilizing 0.8 millisecond pulses 15 times per second to create a field of 4 volts per meter seem to generate a fright response in sharks longer than 1.2 meters and are being investigated. Their benefits include repulsion rather than shark capture or destruction. Abalone divers in South Australia work from one-man, self-propelled shark cages. Experimental devices for individuals include chain mesh diving suits, inflatable dull-colored plastic protective bags (yellow is easy for aircraft to spot, but most attractive to sharks), acoustical and handheld electrical field transmitters, and surfactants and other chemical repellents. Glandular extracts from the Moses sole flatfish *Pardachirus marmoratus* found in the Red Sea and western Indian Ocean contain shark-repellent lipophilic substances. However, it has been estimated that about 24 kg of any effective chemical repellent would have to be contained in the volume of water through which a slowly-approaching shark might swim as it attacked a human in the ocean. At the present time, the concept of a chemical carried in a lifejacket being useful in shark attack prevention is unrealistic.

Dr. Paul Auerbach is a partner at Delphi Ventures in Menlo Park, California and Clinical Professor of Surgery in the Division of Emergency Medicine at Stanford University. He is an editor of the textbook *Wilderness Medicine* and author of *Medicine for the Outdoors*. He is a member of the board of directors of the Wilderness Medical Society and serves as an advisor or consultant to numerous outdoor organizations, including the Divers Alert Network and the National Ski Patrol System.

“Society News,” continued from page 1

For additional information and updates, please visit the ISTM web site at [www.istm.org](http://www.istm.org) or e-mail Lori Kalata, Examination Coordinator, at: [lkalata@wi.rr.com](mailto:lkalata@wi.rr.com).

## Practice and Nursing Issues Committee News

As we head into Spring, the Practice and Nursing Issues Committee is busy with various projects on behalf of the membership. To remind you of who and what we are, the committee works under the umbrella of the Professional Education and Training Committee to monitor and address practice and professional issues, particularly those of specific relevance to nurses. Although we are focused largely on nursing issues, we wish to foster the inter-disciplinary approach to travel health. Indeed, one of our main aims is to encourage multidisciplinary collaboration in practice.

In common with many others in ISTM, we are trying to promote communication and collaboration among professionals involved in travel health worldwide. A great way of achieving this is through the setting up of local, regional and national travel health groups. This has happened successfully in several countries. In the UK, for example, what started as a small interested group of nurses in 1990, has now evolved into a national travel health forum with several thousand members. In the US there is an active movement to promote local and regional networks of travel health nurses. In the New York City region, a group of thirty enthusiastic travel health nurses have been meeting regularly since 1999. They have established a website, [www.travelhealthnursing.com](http://www.travelhealthnursing.com), dedicated to travel health nursing and to share information and encourage communication. If any of you out there are thinking about setting up a group in your own area, but are in need of a bit of guidance about how to go about it, please get in touch with us.

One of the committee's most exciting tasks at the moment is helping to make the next ISTM conference as enjoyable,

interesting and relevant as possible for nurses. Innsbruck was great in terms of nurse input and stimulating program content, and we are sure that CISTM8, New York 2003 will be even better. We will also be working to help ensure that continuing education units/points (CEU) are available for nurses attending the conference.

Still on the topic of CISTM8 – we once again encourage those of you who have carried out interesting work or research, to please submit your proposals for presentation in New York. We know there is a lot of good work going on out there – so please share it with the rest of us. If some of you are thinking about carrying out a piece of work but don't know where to start, the good news is that the committee is working on a packet comprising basic guidance on what to consider prior to commencing a research project – so watch this space.

Signing off for now.....

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## Health of Migrants and Refugees Committee News

### The Migrant as a Traveler—Visiting Friends and Relatives

One of the many changes in the area of migration health during the past two decades has been the increasing mobility of many migrant populations after they have resettled in their new country of residence. The reasons behind increased travel in migrant communities reflect general factors of globalization common to other travelers, and to shifting geopolitical environments. These patterns of mobility have direct relevance for travel medicine. Bet-

ter awareness of these changes by practitioners can provide increased opportunities for risk identification and risk management for this growing population of travelers.

Traditional patterns of immigration and refugee flows from the end of the Second World War to the mid-1980s tended to be unidirectional. Often, the financial limitations encountered by migrant family groups following arrival at their new homes did not offer the capacity for frequent return journeys to their place of origin. Depending on cultural, social and assimilation factors, family visits to the “old country” frequently took place many years after migration, or generations later. In the case of refugee movements during the East/West geopolitical environment before the fall of the Soviet Union, return visits to the migrants original home were even less common, and in some situations almost impossible during the life time of the original migrant.

Current travel patterns for many groups of migrants are now much different than those of relatively few years ago. The availability and ease of moderate and low priced travel allows frequent journeys to visit friends and relatives (VFR) remaining in the migrants source country, and also allows travel to other destinations, representing various health risks. Also, as military and political conflicts are increasingly resolved through international interventions, opportunities for refugees and asylum seekers to return to their previous homelands have increased.

While these patterns of increased mobility are related to general changes in global travel, there are some issues in VFR travel in migrant communities that can be associated with increased risks of travel-related diseases and ill health. VFR travel, even to the same destinations as traditional tourists, often varies in risk potential. These differences are observed in the duration of travel, accommodation and exposure to local risk factors, the awareness and appreciation of risk, the use of local food, water, and health care facili-

*Continued on page 6*

ties, and the frequency of seeking pre-travel health advice. (1)

The purpose of VFR travel also differs from tourist travel in a number of aspects that include cultural, social and economic factors. Journeys are often of longer duration to allow for distant family members to spend time together to sustain the family network. In the developing world there is an increased risk of acquiring illness. VFR travelers are more likely to reside in the community as opposed to commercial accommodations. While these risks may be low or marginal in VFR travelers who were born and recently lived in the location, children born after immigration or those who have been absent from the local environment for many years may have decreased immunity to specific infectious agents, and may be more susceptible to common local pathogens. Malaria occurring in returning VFR migrant travelers is frequently noted in Europe and North America. (2), (3), (4)

While chronic risks of endemic disease (malaria, for example) are part of the normal existence for local residents, interventions to reduce risks may not be considered by the migrant traveler or their physicians. For these travelers the journey is simply a return home where risks to health in the travel medicine context are not considered in the same manner as in tourist travelers. Travel medicine preparations and counseling may not enter into VFR travel planning, or if they do the appreciation and risk acceptance may differ significantly from tourist travelers to the same destination. Examples extend beyond malaria prevention. VFR travelers may not realize that some infections commonly encountered in early childhood such as hepatitis A, for example, may have more serious clinical consequences in populations with low immunity such as in older children and adolescents who were born to migrants in the developed world. (5)

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“Society News,” continued from page 5

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### Travel Medicine in Japan.

In Japan, there are two societies that deal with travel medicine: the Japanese Society of Travel and Health, and the Japanese Society of Travel Medicine.

The Japanese Society of Travel and Health will hold its 6<sup>th</sup> annual meeting on July 5<sup>th</sup>, 2002 at Haneda International Airport in Tokyo. The President is Hirofumi Okoshi MD, PhD of the Medical Services,

Japan Airlines. This Society was founded in 1997 to study various health issues among overseas travelers and employees working in foreign countries. The Society has about 200 members. These include medical doctors, nurses, and non-medical personnel. The annual meetings focus on developing travel medicine in Japan. We sincerely hope that many people will be joining us in making a fruitful meeting.

In 2001, the Japanese Society of Travel Medicine was established. The mission of this Society is to promote healthy travel for Japanese travelers, many of whom go abroad with almost no preparation for health risks.

Japanese travelers are becoming increasingly aware of the importance of travel medicine, and not only about infectious diseases, but of the much wider range of health and safety issues. The Society's aim is to teach travelers how to cope with these risks according to their statistical importance. The most urgent tasks are to support the elderly who have heart attacks and strokes during travel, educate travelers about high altitude illness, facilitate travel for the physically challenged, and inform travelers about sexually transmitted diseases.

A meeting has been scheduled for March 9, 2002 in Tokyo, with lectures and symposia. Invited lecturers include Professor Walter Pasini from the WHO Collaborating Centre for Tourist Health and Travel Medicine, and Dr. John Aldis of the U.S.A.

Yuka Ujita

Japan Overseas Health Administration  
Center

### “Personal Safety Advice for Travelers Abroad” Recognized

For the information of readers, I am pleased to advise that a paper published last year in the *Journal of Travel Medicine*, was granted a prestigious award

Continued on page 9

# Calendar: Travel Medicine Conferences, Courses, Educational Travel

## Conferences

March  
19-21

**Introduction to Travel Medicine, A Short Course.** London UK. March 19-21, 2002. Comprehensive, preparatory three-day course covering theoretical and practical aspects of travel medicine in practice. Contact: Ruth Hargreaves, Course Administrator, Academic Centre for Travel Medicine and Vaccines, Royal Free Campus, Rowland Hill Street, London NW3 2PF UK Email: r.hargreaves@rfc.ucl.ac.uk Tel: +44 020 7472 6114 Fax: +44 020 7830 2268

April  
8-12

**Travel Medicine: Short Course.** London, UK April 8-12, 2002. London School of Hygiene and Tropical Medicine (LSHTM.) The course is designed for general practitioners and nurses who provide pre-travel health service and want to update their knowledge and skills. Registry LSHTM, 50 Bedford Square, London WC1B 3DP, UK. Tel: +44(0)20 7299 4648. Fax: +44(0)20 7323 0368. Email: shortcourse@lshtm.ac.uk Internet: http://www.lshtm.ac.uk

April  
13-17

**International Conference on Travel Medicine and 2<sup>nd</sup> International SHEA (Society for Healthcare Epidemiology of America) Training Course in Healthcare Epidemiology.** Riyadh, Kingdom of Saudi Arabia. April 13-17, 2002. "Global Travel: The Raptures, The Risks." Topic to be discussed: travel epidemiology; venomous snakes. Hajj-related diseases; drug resistant diseases. International Faculty including president and two past presidents of the ISTM. In collaboration with WHO, ISTM, and other organizations. Contact: Conference Coordinator, Academic Affairs, P.O. Box 22490, Riyadh 11426 Tel: 252-0088 ext 2328 Fax: 252-0040 E-mail accaff1@ngha.med.sa Website: http://academic.ngha.med.sa

April  
24-27

**5<sup>th</sup> Wilderness and Travel Medicine Meeting.** Santa Fe, New Mexico. April 24-27, 2002. Update on all important, recent happenings in travel and wilderness medicine. Sponsored by the Wilderness Medical Society and University of California, San Diego Continuing Medical Education (CME) Program. Contact: CME, 9500 Gilman Drive, San Diego, CA 92110. Tel 858-534-3940. Fax: 858-534-7672. Email: ocme@ucsd.edu Web address: www.wms.org

May  
10-12

**The Third Annual Travel Medicine Course : Certificate of Competence.** Johannesburg, South Africa. May 10-12, 2002. University of the Witwatersrand in conjunction with the James Cook University, Townville, Australia. Hosted by the South African Society of Travel Medicine. Open to medical practitioners, nurses, pharmacists and paramedics. The course comprises two "on campus" modules, and two inter-block projects, a course reader and a MCQ examination. On campus contact time will comprise lectures, case studies and discussions. It is registered for CME/CPD points with the HPCSA and covers material pertinent to the ISTM Certificate of Knowledge in Travel Medicine Examination. Contact : Michelle Shelby, Secretary, SASTM, Office, P.O. Box 16179, Lyttelton, 0140 Republic of South Africa. Tel: +27 (0)12 667-5160 E-Mail: sasomdm@iafrica.com Web site: http://www.sastm.org.za

May  
15-18

**III European Conference on Travel Medicine: Travel and Epidemics.** Florence, Italy. May 15-18, 2002. A broad overview of the latest in travel medicine from leaders in the field. Sponsor: WHO Collaborating Centre for Tourist Health. Official Language: English. Contact: Dr. Walter Pasini Viale Dardanelli, 64 47900

Rimini, Italy Tel. +39-0541-24301 or +39-0541-53209. Fax +39-0541-25748. E-mail: wpasini@rimini.com. Or contact: Conference Secretariat: Travel Agency Girovagare, Viale Milton n. 81, 1- 50129 Firenze, Italy. Tel: 39 055 494949. Fax: 39 055 476393.

May  
22-24

**3<sup>rd</sup> Scandinavian Forum for Travel Medicine 2002.** Copenhagen, Denmark. May 22-24, 2002. Sponsors: Travel medicine societies in Denmark, Sweden and Norway in collaboration with WHO. A focus on the scientific basis for travel medicine through state-of-the-art reviews, symposia, and free communications. Health risks when traveling to Eastern European countries. Official language: English - with parallel sessions in Scandinavian languages. Contact: Conference secretariat: ICS A/S Copenhagen, Strandvejen 171, P.O. Box 41, DK-2900 Hellerup Denmark. Tel: +45 3946 0500 Fax: +45 3946 0515. Email: forum2002@ics.dk Web address: www.ics.dk

July  
10

**3<sup>rd</sup> Annual Study Day in Travel Health. London. UK** July 10, 2002. The course is open to all Health Care Professionals with an interest in travel medicine. It will be a useful update for those providing pre-travel health advice in a primary care setting. Contact: Ruth Hargreaves, Course Administrator, Academic Centre for Travel Medicine & Vaccines, Royal Free Campus, Rowland Hill Street, London NW3 2PF Tel: +44 020 7472 6114, Fax: +44 020 7830 2268. Email: r.hargreaves@rfc.ucl.ac.uk

Sep  
8-12

**Third European Congress on Tropical Medicine and International Health.** Lisbon, Portugal September 8-12, 2002. "Tropical Medicine: A Global Challenge." Under the auspices of the Federation of the European Societies for Tropical Medi-

## Calendar (continued)

cine and International Health. Hosted by the Instituto de Higiene e Medicina Tropical. This Conference will concentrate on tropical medicine, travel medicine, migration, medicine, and international health, involving different experts to explore future innovative collaboration. Official language: English. Local Committee Chairman: Professor Dr. F. Antunes, Instituto de Instituto de Higiene e Medicina Tropical, Rua da Junqueira, 96 PT-1600 Lisbon Tel: ++351-21-365-2638 Fax: ++351-21-797-6242 Email: ip231874@ip.pt Web address: www.kit.de/tropical2002

Oct-  
July

**Diploma Course in Travel Health and Medicine. London UK.** Course taught from October 2002-July 2003 on each Monday.

Provides postgraduate education and a qualification within the field of travel medicine to those actively involved or with a keen interest in the provision of travel advice. Open to both registered medical practitioners qualified with MBBS and nurses qualified with RGN, and other health care professionals holding relevant qualifications. A Diploma in Travel Health and Medicine (Royal Free & University College London Medical School, University of London) will be issued to those that successfully complete the course. Contact: Ruth Hargreaves, Course Administrator (Dr Jane N Zuckerman, Course Director) Academic Centre For Travel Medicine and Vaccines Royal Free and University College London Medical School Rowland Hill Street London NW3 2PF United Kingdom Tel: (44) 020 7472 6114 Fax: (44) 020 7830 2268 Email: r.hargreaves@rfc.ucl.ac.uk

Oct  
20-23

**IV Biennial Asia Pacific Travel Health Conference.** Shanghai, China: October 20-23, 2002. Travel Health in the Asia

Pacific Region: New Frontiers and Challenges. Sponsor: Asia Pacific Travel Health Society Official language: Official language: English – with simultaneous translation of the plenary meetings into Chinese. Contact: Ms. Zhou Yifan, Secretariat of 4APTHC, Room 1705, No. 2669

Xie Tu Road, Shanghai 200030 China. Tel: 86-21 64398193. Fax: 86-21 64398194. Email: apthc2002@sh163.net Web address: www.2002APTHC.NET

May  
7-II

**CISTM8 8<sup>th</sup> Conference of the International Society of Travel Medicine.** New York. May 7-11, 2003. Contact: CISTM8

Conference Secretariat: Talley Management Group, Inc., 19 Mantua Rd. Mt. Royal, NJ 08061 USA. Tel: (856) 423-7222 Ext 218. Fax: (856) 423-3420. Web address: www.istm.org.

### Courses/Educational Travel.

**Tropical Medicine Expeditions to East Africa:** 10th Expedition to Kenya, February 23-March 7, and 7th Expedition to Uganda,

March 23-April 4, 2003. In collaboration with the University of Nairobi and Dr. Kay Schaefer (MD, PhD, MSc, DTM&H) Cologne, Germany. Official language, English. The expedition is designed for a limited number of physicians, public health experts and scientists. During the 2 week-expedition the participants will visit different hospitals and health projects in urban and rural areas. Includes individual bedside teaching, laboratory work, and lectures in epidemiology, clinical findings, diagnosis, treatment and control of important tropical infectious diseases. Also, updates on Travel Medicine and visit to the "Flying Doctors" headquarters in Nairobi. 50 contact hours. Accredited certificate given. Contact: Dr. Kay Schaefer, Tel/Fax: +49-221-3404905, E-Mail: contact@tropmedex.com Homepage: www.tropmedex.com

June  
8-28

**Medical Practice with Limited Resources.** Ifakara, Tanzania. June 8-28, 2002. Organized by the Swiss Tropical Institute.

Three-week course to teach clinical tropical medicine within the health facilities of tropical countries. Official language: English. Contact: Swiss Tropical Institute, Course Secretariat, Socinstrasse 57, CH-4002 Basel, Switzerland. Tel: +4161 284 82 80. Fax: +41 61 284 81 06. Email: courses-sti@unibas.ch Web address: www.sti.unibas.ch

Jan  
27 &  
March  
28

**The Gorgas Course in Clinical Tropical Medicine** Lima, and the Andes and Amazon regions, Peru. Course scheduled for January 27- March 28, 2003, and for 2004. Sponsored by

the University of Alabama and the IAMAT Foundation. Includes lectures, case conferences, diagnostic laboratory procedures, and bedside teaching in a 36-bed tropical medicine unit. Official language: English. International Faculty. 380 contact hours. Contact: David O. Freedman, M.D. Gorgas Memorial Institute, University of Alabama at Birmingham, 530 Third Avenue South, BBRB 203, Birmingham, AL 35294. Fax: 205-934-5600 Or call: The Division of Continuing Medical Education at 800-UAB-MIST (U.S.) or 205-934-2687 (from overseas) Email: info@gorgas.org Web address: www.gorgas.org.

## IMPORTANT DATES

Conference	May 7-11, 2003
Early Registration	December 2002
Regular Registration	March 2003
Abstract Submission	January 2003
Hotel Reservation	March 2003





"Society News," continued from page 1

from the Australian Military Medicine Association (AMMA). The paper, "Personal safety advice for travelers abroad",<sup>1</sup> won the AMMA Patron's Prize for the best article published in a peer-reviewed journal by an AMMA member in 2001. The award is endorsed by the Patron of AMMA, the Surgeon General of the Australian Defence Force, currently Air Vice Marshall Bruce Short.

Published in a "Common Questions" format, the paper emphasized that, "although many travelers were concerned about their personal safety when traveling aboard, it was an often neglected area of travel medicine".<sup>2</sup> "Personal safety is one of the most important areas for travel health advisers to cover when giving advice to travelers going virtually to any country, particularly as fewer people are going on programmed package tours".<sup>2</sup> It mentioned that "travelers should also be advised about important safety nets, such as health and travel insurance and finding medical assistance abroad".<sup>2</sup> The paper "covered several topics including how to avoid trouble spots, vehicle safety and managing security issues abroad, and also touched on the issue of terrorism".<sup>2</sup>

I wish to gratefully acknowledge my co-author, Dr Mathew Klein, Principal Medical Adviser, Department of Foreign Affairs and Trade, Canberra, Australia, as well as the editorial and publishing teams for the *Journal of Travel Medicine*.

Peter Leggatt MD

Dr. Leggatt is an Associate Professor in the School of Public Health and Tropical Medicine, James Cook University, and Directorate of Medical Services, Defense Health Service, Army Reserves, Townsville, Queensland, Australia.

#### References

Leggatt PA, Klein M. Personal safety advice for travelers abroad. *J Travel Med*. 2001;8:46-51.

Anonymous. Article wins prestigious award. *Townsville Bulletin*. Friday December 21, 2001:5.

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