



## CISTM8 Invitation

Dear Colleagues:

On behalf of the Local Organizing Committee of the International Society of Travel Medicine (ISTM), I am pleased to invite you to attend the 8<sup>th</sup> Conference of the International Society of Travel Medicine to be held in New York City at the Marriott Marquis Hotel in the heart of Times Square from May 7-11, 2003.

The goal of our New York conference is to share the advances in the science and art of travel medicine, while providing a world class location for you to enjoy with colleagues from around the world. Formats will include Plenaries and Symposia, Debates, Workshops, Original Scientific Presentations, Meet-the-Experts, Case of the Day and abstract presentations. Satellite programs and sponsored events will also be offered.

New York City provides an unmatched venue for the international community and an exciting opportunity for us to share our story about healthy travel with the world media. The social program promises attendees and their guests magnificent sightseeing, world-class shopping, as well as a wide array of unparalleled cultural events and entertainment. The Metropolitan Museum of Art, the Guggenheim, Museum of Modern Art, American Museum of Natural History, the Statue of Liberty, Ellis Island and the World Trade Towers are just a few of the attractions. Broadway offers an array of theatrical experiences and Lincoln Center provides musical events and ballet, all within walking distance or a short cab ride from the hotel. New York boasts some of the finest restaurants in the world with the cuisine of every nation represented. For the sports minded, baseball will be in full swing at Yankee and Shea Stadiums.

On behalf of the Scientific Chairs and Local Organizing Committee, we look forward to welcoming you to this landmark 8<sup>th</sup> CISTM. You will have a most rewarding scientific, cultural and social experience.

Bradley A. Connor, MD  
Organizing Chair

**CISTM8 SCIENTIFIC PROGRAM COMMITTEE**  
Chair, Hans Dieter Nothdurft, MD (Munich, Germany)  
Co-Chair, David Freedman, MD (Birmingham, USA)

### IMPORTANT DATES

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



## Denali Mountain Medicine

By Colin Grissom, MD

(The borders between traveling and mountaineering are becoming blurred as remote mountains become more accessible. Many individuals with little climbing experience and only a vague knowledge of altitude-related illnesses are attempting to reach summits of high peaks for which they are not properly prepared. Many become ill and are injured. Here is the experience of a medical team on one such mountain.)

**D**enali (formerly known as Mt. McKinley) is the tallest mountain in North America at 6,194 meters, and is unique among the high mountains of the world because of its proximity to the arctic circle at 63 degrees North latitude. During the climbing season of May to July arctic conditions exist higher on the mountain. Temperatures at night during May are -29 to -40 Celsius at the 4,200 to 5,100 meters level, and storms with winds of 80 to 160+ kilometers per hour can occur during May and June and last for several days. Because of its northern latitude the barometric pressure on Denali is lower for a given altitude than on mountains closer to the equator. This difference becomes noticeable above 3,000 meters and makes the summit of Denali physiologically equivalent to a 6,300 to 6,900 meters peak in the Himalayas.

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### Climbers on Denali

As one of the “seven summits” (the highest mountain on each continent), Denali is an internationally known mountain that attracts a large number of climbers. Of the 1,110 climbers attempting Denali in 1997 about 90%, or around 1,000 climbers, spent part or all of their expedition on the West Buttress route. Of the 1,110 climbers 51% were successful in reaching the summit; 38% were from outside the USA.

### The National Park Service camp on Denali

Because of the large number of climbers that attempt the West Buttress route and stay at 4,200 meter for acclimatization and preparation for summit attempts, the U.S. National Park Service (NPS) maintains a camp there. The camp sits on a large glacial plateau and is at an ideal elevation for acclimatization prior to a move to the 5,100 meter high camp, from which the summit is attempted. Consequently during the peak climbing season of mid May to mid June there are typically 100 to 200 climbers at the 4,200 meter camp at any one time.

This camp consists of two small heated walk-in shelters (a Weatherport TM and

a “Clamshell” made by the same company). One shelter is used for cooking and communication equipment and the other for medical care. The NPS camp is occupied by the acclimatized rescue team which consists of an NPS climbing ranger, volunteer climbers, and a volunteer doctor. One or two para-rescue personnel from the Alaska Air National Guard are also part of the rescue team. The Alaska Air National Guard provides support to the camp in terms of medical supplies, tents, and rescue equipment.

The function of the NPS camp are several: 1) to serve as an information resource for climbers on the mountain with questions about acclimatization and strategies for a safe summit attempt, 2) to provide medical care to sick or injured climbers, and 3) to rescue sick or injured climbers higher on the mountain. Medical research on high altitude illness is also conducted at the camp by some of the volunteer doctors under separate funding.

### Rescue on Denali

The NPS provides for rescue of climbers who become ill or injured when it is considered appropriate, based on the evaluation of field personnel. Factors considered in mounting a rescue are the degree of urgency of the problem, whether the

climber and his party could safely self evacuate and, of paramount importance, the safety of the rescue party. Rescue is sometimes precluded or postponed by storms and cold weather conditions. The NPS mountaineering handbook for Denali states that “Rescue is not automatic. Denali National Park and Preserve expects park users to exhibit a degree of self-reliance and responsibility for their own safety commensurate with the degree of difficulty of the activities they undertake.”

Personnel and resources of the NPS available to assist with rescues on Denali include the climbing ranger and volunteers occupying the 4,200 meter camp, the NPS Lama helicopter based in Talkeetna, (which is off the mountain) and the NPS at the ranger station in Talkeetna - where the incident commander for all major rescues is located and where logistics are coordinated.

Utilizing the helicopter for rescue and evacuation is not automatic. The nature of the medical problem (i.e. life threatening) is balanced against risk to the rescuers and weather conditions. For example, a non-life threatening injury, such as a broken ankle, at 5,400 meters, would most likely be evacuated on the ground despite

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the time and manpower it would require, because the injury does not warrant the risk of landing the helicopter at that altitude. Once ground evacuated to 4,200 meters a broken ankle might be evacuated by helicopter if the weather was good and the patient was not ambulatory. In contrast, a climbing fall, where injuries and problems might include hypothermia, frostbite, long bone fractures, and a closed head injury, would be helicopter evacuated from the nearest safe landing zone at 5,100 to 5,700 meters, weather permitting.

Military rescue personnel that sometimes assist with rescues include the Army High Altitude Rescue Team (HART). HART operates the Chinook helicopter which has the capability to land at altitudes up to 5,900 meters, but has no ground rescue capability. The Alaska Air National Guard also sometimes assists with rescues, and has the personnel to provide ground rescue, but the altitude ceiling for their Pavehawk helicopter is 3,000 to 3,600 meters.

### Trauma due to climbing falls

Severe trauma on Denali is almost always the result of a climbing fall. Response time to such events is at least two hours, even for a fall witnessed from the 4,200 meter camp, and may take as long as 12 to 24 hours, depending on the weather. Because of the long response time climbers who have suffered injuries that require surgical intervention within several hours do not survive. Climbers may also die from hypothermia before the rescue team can reach them. Because of these factors, climbers who are injured in climbing falls and survive generally do not have immediate life threatening injuries from the fall, but they all have life threatening hypothermia and usually severe frostbite by the time the rescue team reaches them. Principles of treatment generally involve immobilizing fractured extremities and the spine if clinically indicated, warm IV fluids, supplemental oxygen, and packaging in a sleeping bag and litter for lowering or helicopter evacuation. Helicopter evacuation from the nearest safe landing zone is optimal.

## High altitude illnesses on Denali

### Acute Mountain Sickness

Acute mountain sickness (AMS) is a symptom complex seen a few hours to a few days after ascent to altitudes above 2500 meters. Most individuals with AMS present with a mild form of the condition, characterized by headache in association with one or more of the following: lassitude, insomnia, anorexia, nausea, dizziness, or peripheral edema. More severe AMS is characterized by an altered level of consciousness, ataxia, or cough with shortness of breath at rest. Such symptoms suggest that AMS has progressed to high altitude cerebral edema (HACE) or high altitude pulmonary edema (HAPE). HACE and HAPE are generally associated with more rapid ascent to higher altitudes. AMS is usually benign and self-limited. HAPE or HACE are potentially life-threatening conditions, especially if further ascent is undertaken.

The incidence of AMS on Denali is about 30 to 50% and is most often mild to moderate in severity. Most climbers treat their AMS by halting ascent, resting, and using analgesics for headache. Descent is always effective therapy, and is recommended in more severe cases. Drug therapy with acetazolamide or dexamethasone may be used to speed resolution of symptoms.

### High Altitude Cerebral Edema (HACE)

HACE is characterized clinically by progression of global cerebral signs and symptoms in the setting of AMS. The hallmarks of HACE are truncal ataxia (walking as if one who had too much alcohol to drink), severe lassitude, and altered consciousness. Left untreated, HACE progresses from confusion and impaired mentation, to drowsiness, obtundation, coma and death. The mechanisms leading to HACE are presumably similar to those causing AMS, and HACE may be considered the severe form of AMS. Therefore a person with AMS who

becomes confused or starts staggering when they walk is developing HACE. Immediate descent is mandatory to prevent progression and death. Recovery is not as rapid as in AMS or HAPE; ataxia and altered mental status may persist even after descent of several thousand meters. Oxygen, if available, should be administered with descent both to improve oxygenation and because HACE is often associated with HAPE. Dexamethasone should be administered by whatever route available in doses of four to six milligrams every six hours. If descent is impossible because of weather or terrain conditions, a portable hyperbaric chamber is an alternative but should not delay descent.

On Denali patients with HACE are often times recognized at 5,100 meters and are immediately ground evacuated by litter to 4,100 meters (or air evacuated from 4,100 meters, weather permitting). Supplemental oxygen and dexamethasone, 8 mg initially then 4 mg every six hours, are the mainstays of therapy. Patients tend to remain severely ataxic even if other neurologic symptoms resolve, and therefore are helicopter evacuated as soon as weather permits - which may take days. A portable hyperbaric chamber is available in the rescue cache at 5,100 meters if descent to the 4,200 meter medical camp is impossible because of weather or terrain conditions.

### High Altitude Pulmonary Edema (HAPE)

HAPE is a form of pulmonary edema that occurs after acute ascent to high altitude greater than 2500 meters. HAPE is a non-cardiogenic pulmonary edema, which by definition means that the flooding of alveoli with fluid is not due to heart failure, but rather to a leak in the pulmonary blood vessels. The incidence of HAPE varies with rate of ascent and ultimate altitude attained. Incidence has been reported as high as 15% in Indian troops airlifted from sea level to altitudes between 3,500 meters and 5,500 meters, but only 2% in

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climbers making a more gradual ascent to 6,150 meters on Denali, and 0.01% in skiers at 2,500 meters in the Colorado Rockies. Contributing factors to HAPE may include exertion, cold ambient temperature, and a pre-existing upper respiratory infection. The clinical presentation includes symptoms of fatigue, shortness of breath at rest, marked decrease in exercise tolerance, and a dry cough that progresses to a cough productive of white frothy sputum.

Treatment of HAPE consists of improving oxygenation either with descent to a lower altitude or administration of supplemental oxygen. Mild to moderate cases of HAPE respond well to therapy with resolution of symptoms within hours after descent of 1000 meters. Untreated, HAPE may rapidly progress to death in less than 24 hours.

On Denali HAPE is treated with supplemental oxygen via nasal canula or face mask overnight, and arterial oxygen saturation is monitored and maintained above 85%. Patients usually sleep in the medical shelter and then descend with their climbing team the next day to at least the 3,300 meter camp. HAPE is almost always self-evacuated with the help of the patients' climbing team. Helicopter rescue is only used when there is associated cerebral edema. Climbers with HAPE are instructed to descend to at least 3,300 meters, or lower if symptoms are not resolved at that altitude. After at least a three nights stay at 3,300 meters climbers may reascend if they desire, and sometimes eventually reach the summit without recurrence of HAPE.

*Colin is a physician for the U.S. National Park Service, 14,000 Ft. Medical Camp, Mt McKinley (Denali), Alaska. He is also an Instructor of Medicine at the University of Utah School of Medicine, Pulmonary and Critical Care Division, LDS Hospital, Salt Lake City, Utah. This article is a summary of his presentation at the Winter Wilderness Medical Course in Breckenridge, Colorado. The course was sponsored by the Wilderness Medical Society.*

## Statistics for Beginners

Ed Ryan, MD, DTM&H

**A**n informal survey of our members showed that many would like to improve their understanding of statistics. This is the first part of a three-part article.

### Evaluating Medical and Scientific Studies/Papers

Understanding scientific/medical studies or research projects/papers requires a knowledge of a number of fundamental statistical concepts. The first concerns study design:

#### Types of studies

A **case control study** is a retrospective study in which individuals have already developed a certain condition. These individuals are compared to control individuals. As an example, let us imagine that we want to study the relationship between smoking and lung cancer. We would first identify individuals who have developed lung cancer. We would then compare them to control individuals. We could then evaluate whether smoking frequencies are different between the two groups. The major shortcomings of this type of study are that the study is retrospective, recall bias could exist, and unintentional/unknown bias can also be introduced in both the selection of cases and the selection of controls. Ideally the individuals are as similar as possible; however, unknown, but confounding, differences could exist.

In a **cohort study**, groups of individuals are identified and followed over time. Continuing our example, we could identify individuals who smoke and those who do not, and follow them over time to see if the incidence of lung cancer between the two cohorts is different. Shortcomings of this type of study are the longitudinal nature (which may take years or decades for an individual to develop a disease or endpoint) and confounding influences.

The **randomized clinical trial (controlled clinical trial)** is usually considered the gold standard for studies. Ran-

domized clinical trials are prospective studies in which individuals are randomized to at least one of two groups and followed longitudinally over time. If the assignment is completely random (to both the study participants and to the researchers), it is called a **double-blinded randomized trial**. An example would be a study which randomly compares two drugs for the treatment of salmonellosis. Individuals can be assigned to receive either drug A or drug B (one of the drugs may even be a placebo). (The drug preparations should look the same. They should taste the same. They should be administered on the same dosing schedule, etc. for true blinding). There should be no way to distinguish between the two groups of study participants. The major advantage of this type of study is that the random nature of group assignment should eliminate unsuspected (or suspected) confounding influences.

Case control and cohort studies are also referred to as observational studies because no intervention is attempted.

Once you understand study design, the next areas to understand involve study **assignment, assessment, analysis, interpretation and extrapolation**. We have already seen that bias can be introduced in **assignment** of individuals to one group or another (especially in the observational studies). The **assessment** should involve an appropriate measurement (one that is relevant to the study). It also should be accurate and precise. Recording bias can make a measurement inaccurate. A precise measurement can also be made with an inaccurate test. For instance, if one is evaluating the incidence of gastritis relating to new medicines by upper GI series as opposed to endoscopy, measurements may be very precise, but they are probably not very accurate. Assessments should also be complete. For instance, individuals may drop out of a study. If those individuals are not included in fi-

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nal analysis (and they all died because of the new drug), the new drug would not be truly evaluated.

**Analysis** of a study rests to a large extent on testing the statistical significance between groups. This occurs in five steps.

1. The first step is to state the hypothesis. **This should be performed before collecting the data.** A common pitfall of studies is to first collect the data and then to analyze the data for comparisons that reach statistical significance. Such a fishing expedition may uncover real differences, but it can also uncover differences related to chance comparisons. For instance, if one were to evaluate a hundred variables that are totally unrelated, one could assume by random distribution that 5 of those 100 or 1 in 20 will show a statistically significant difference (even though no such difference exist).

2. The second step is to formulate the null hypothesis. In this step, the investigators assume that no true difference exists between the study group and the control group. This is known as the **null hypothesis**.

3. The third step is to decide the statistically significant cut-off value. Usually, this is a cut-off value of 5%. This means that if a difference is shown between the two groups, that there is a 95% chance that that difference is true (or less than a 5% chance that the difference is due to chance alone).

4. It is only the fourth step in which the data are actually collected.

5. The fifth step applies statistical significance tests. In this step, the investigators determine the probability that a difference between a study and a control group would occur if no true difference existed in the larger population from which both the study and the control group populations were selected. This probability is known as the *P* value. This means that one is calculating the probability that the data would occur if the null hypothesis of no difference were true. There are a number of **statistical tests** which can be cho-

sen to perform the analysis of data. Assuming that the correct statistical tests are chosen, one then attempts to reject the null hypothesis. If a difference (usually if a *P* value of (equal or less than 0.05, i.e. a 5% chance that the result is due to chance alone) is detected, then one can reject the null hypothesis. Obviously the higher the statistical significance, the more likely it is the null hypothesis can truly be rejected. For instance, the *P* value of <0.001 means that there is a <1:1,000 chance that the observed result is due to chance alone.

Differences are usually expressed by comparing means or medians. Both are measures of the center of a distribution. For symmetrical distribution, the mean is a reliable measure of the center or average. The mean can be reported as the arithmetic mean. For instance, if we measure the antibody levels in a number of patients, one of who has a value of 2, and another has a value of 3, another has a value of 4, another has a value of 5, and another has a value of 20, the mean would be a summation divided by the number evaluated (2 + 3 + 4 + 5 + 20 [equals 34] divided by 5 = 6.8). If the data are not symmetrically distributed, data can be reported as a geometric mean. This lessens the likelihood that an “outlier” will skew data analysis. For instance, in the above example, the individual who had the value of 20 skews the data upward but is weighted equally to the other values. The geometric mean is calculated by multiplying the values and taking the root to the  $n$  ( $2 \times 3 \times 4 \times 5 \times 20$  taken to the root 5 = 4.7).

Standard deviation expresses the spread of individual observations around the mean. A standard deviation is the square root of the variance. Variance is the measure of the spread of variability of quantitative measurements. The standard error of the mean indicates the degree of uncertainty in calculating estimate from a sample. A standard error can be calculated from the standard deviation by dividing the standard deviation by a square root of  $n$  (with  $n$  representing the number of values measured).

*“An informal survey of our members showed that many would like to improve their understanding of statistics. This is the first part of a three-part article.”*

The median is the value which divides the data in half; 50% of the observations have values lower than the median, and 50% have values greater than the median. The median is also referred to as the 50<sup>th</sup> percentile. For symmetrically distributed data, the mean +/- a standard deviation is usually reported; for non-symmetrical data (non-parametric data, see below), the median and 25<sup>th</sup> & 75<sup>th</sup> percentiles are usually reported.

Range refers to the interval from the minimum to the maximum value in a set of quantitative measurements. For instance, the arithmetic mean in our example would be 6.8, the geometric mean would be 4.7, the median would be 4, and the range would be 2 through 20.

*Ed is Director of Tropical and Geographic Medicine, and Director of the Traveler's Advice and Immunization Center, Division of Infectious Diseases, Massachusetts General Hospital, in Boston. This article is based on a course in statistics that he gave at the Intensive Review Course in Clinical Tropical Medicine and Travelers' Health in Toronto. The course was sponsored by the American Society of Travel Medicine and Hygiene in cooperation with the American Committee on Clinical Tropical Health and Travelers' Health.*

# Calendar: Travel Medicine Conferences, Courses, Educational Travel

## Conferences (2001)

**Sept  
28-30  
&  
October  
12-14**

**Wilderness & Travel Medicine for Primary Care Providers.** San Diego, September 28-30, 2001. Orlando, October 12-14, 2001. Sponsor: Wilderness Medical Society (WMS), Weekend courses. "In a shrinking world, every primary care provider must be familiar with basic wilderness and travel medicine. WMS, 3695 E. Fountain Blvd. Ste. A1, Colorado Springs, CO 80910. Tel: 719-572-9255. Contact: Email: wms@wms.org; Web address: www.wms.org

**October  
11-13**

**Medizin und Mobilität.** Oberpfaffenhofen (near Munich), Germany. October 11-13, 2001. German Society for Aviation and Space Medicine in cooperation with the German societies for mountain and expedition medicine, polar medicine, travel medicine, tropical medicine and diving medicine. Official language: German. Contact: DGLRM-Kongresssekretariat Medizin und Mobilität 2001, Institut für Luft- und Raumfahrtmedizin des DLR, Linde Höhe, 51147 Köln, Germany. Fax: 0 22 03/69 52 11.

**Sept 30-  
Oct 3**

**Challenges in Tropical Medicine and Parasitology.** Pontresina, Switzerland September 30 - October 3, 2001. A joint meeting of the Swiss/Italian Societies of Tropical Medicine and Parasitology. Distinguished international speakers will review major problems and achievements in the fields of tropical medicine, parasitology, and travel medicine and provide a forum for the exchange of ideas and data. Contact: Felix Grimm, c/o Institute of Parasitology, Winterthurerstrasse 226a, 8057 Zurich - Switzerland. Fax: +41 (01) 635-8907. Email: sitap@vetparas.unizh.ch/; Web address: www.sstmp.unibe.ch/sitap

**Nov  
19-23**

**54<sup>th</sup> World Congress of the World Thermalism and Climatology Federation (FEMTEC), 2<sup>nd</sup> Latin American Congress of Tourism and Health (FLT), and 3<sup>rd</sup> International Congress of Tourism and Health.** Varadero, Cuba. November 19 - 23, 2001. The use of natural resources to promote health. Official languages: Spanish and English. Contact: Secretary to the Organizing Committee Margarita Roca Sardina, Ave. 43, No. 1418 Esq. a Calle 18, Miramar, Playa, Ciudad de la Habana, Cuba. Tel: (53 7) 24 7218. Fax: (53 7) 24 1330 Email: despacho@sermed.cha.cyt.cu; Web address: www.cubanacan.cu/turismo/salud/index.html

**Nov  
29 & 30**

**12th Conference on the Health of International Travelers.** Montreal, Canada. November 29 and 30, 2001. New vaccines, new clients with the growing popularity of mountain and adventure travels, DVT, HIV PEP for travelers and a broad overview of the latest in travel medicine from leaders in the field. Includes lectures, workshops and case studies. Conferences in English or French - with simultaneous interpretation. Contact: Mrs Nicole Côté or Dr Dominique Tessier, 500, Sherbrooke street, West, suite 1100, Montreal (Quebec) Canada H3A 3C6. Tel: (514) 499-2777-248, Fax: (514) 845-4842. Email: nicco@xchg.me disys.ca; Web site: csvm.ca.

## Conferences (2002)

**Feb  
10-13**

**Winter Wilderness and Travel Medicine Course.** Big Sky, Montana, February 10-13, 2002. Cold weather aspects of travel and wilderness medicine. WMS, 3695 E. Fountain Blvd., Ste. A1, Colorado Springs, Co 80910. Contact WMS Meetings Plus 1-800-800-6819. Email: wms@wms.org; Web address: www.wms.org

**Feb 25-  
March 1**

**8<sup>th</sup> Swiss International Short Course on Travelers' Health.** Basel, Switzerland. February 25 - March 1, 2002. Organized by the Swiss Tropical Institute and under the patronage of the International Society of Travel Medicine A 1-week course providing comprehensive training in all aspects of travel medicine. Official language: English. Contact: Swiss Tropical Institute, Course Secretariat, Socinstrasse 57, CH - 4002 Basel, Switzerland. Tel: +41 61 284 82 80. Fax: +41 61 284 81 06. Email: courses-sti@unibas.ch; Web address: www.sti.unibas.ch

**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, I- 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 39460500 Fax: +45 3946 0515. Email: forum2002@ics.dk; Web address: www.ics.dk



## Calendar (continued)

### Conferences (2002) cont.

**Sept  
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 Medicine 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; www.kit.de/tropical2002/

**October  
22-25**

**IV Biennial Asia Pacific Travel Health Conference.** Shanghai, China: October 22-25, 2002.

Travel Health in the Asia Pacific Region: New Frontiers and Challenges. Sponsor: Asia Pacific Travel Health Society 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  
7-11**

**CISTM8 8<sup>th</sup> Conference of the International Society of Travel Medicine.** (see box, page 1.)

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 (2002)

**Feb  
18-22**

Siem Reap (Angkor Wat), Cambodia. Conference date: February 18-22, 2002. (Travelling date: February 15-25, 2002.)

CME on Travel and Tropical Medicine. Accredited by the University of Toronto. Sponsored by The Centre for Travel and Tropical Medicine, Department of Medicine, Toronto General Hospital. Course organizer: Kevin C. Kain, MD, FRCPC, Director, Centre for Travel and Tropical Medicine, EN G-224, Toronto General Hospital, 200 Elizabeth Street. Toronto, ON, Canada M5G 2C4, Kevin.kain@uhn.on.ca Travel arrangement through: Yue Chi, Concepts East Travel, 120 Eglinton Avenue East, Suite 904 Toronto, Ontario, Canada M4P 1E2 Tel: 416-322-3387 or 1-888-302-1222. Fax: 416-322-3129. E-mail: chiyue@idirect.com

**Jan 28-  
March 29**

**The Gorgas Course in Clinical Tropical Medicine Lima, and the Andes and Amazon regions, Peru.** January 28 -

March 29, 2002 Waiting list only for this date. Course scheduled for 2003 and 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.

**Feb  
3-15  
&  
Feb-  
March**

**Tropical Medicine Expeditions to East Africa.** Kenya, February 3 - 15, 2002. Uganda. February 24 - March 2002. Sponsors: Tropical Medicine Center, Cologne, Germany, University of Nairobi, Kenya, and University of Makerere,

Kampala, Uganda. Official language: English. Expedition designed for a limited number of physicians, public health experts, nurses. Visits to many hospitals and projects in urban and rural areas. Includes bedside teaching, laboratory work, and lectures in the epidemiology, clinical manifestations, diagnosis, treatment and control of all important tropical diseases. 50 contact hours. Contact: Kay Schaefer, MD. Fax: +49 221-340 49 05. E-Mail: contact@tropmedex.com Website: 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

## Letters to the Editor

*(This is a reply to a letter from Kathrin Love, MD asking why ISTM does not have position papers on important topics in travel medicine.)*

Dear Kathrin,

Certainly, position or consensus statements would be helpful for many among travel health professionals. However, as I painfully experienced during my term as ISTM President, this is difficult to achieve.

According to our Society by-laws, Article 4.1, it is our goal "to develop guidelines and recommended principles that will be disseminated to those working in the area". In the past, whenever we tried to agree even on 'simple' topics, some members opposed that on the basis of having differing traditions in specific countries or differing products. It was claimed that unless a recommendation was unanimously supported by the membership, it could not be an ISTM recommendation.

However, times change, and it may be time to reassess such questions in the Executive Board and appropriate committees.

*Robert Steffen, MD, Zurich  
Head, Division of Communicable Diseases  
Director, World Health Organization Collaborating Centre for Travellers' Health  
Institute of Social and Preventive Medicine (ISPM)  
Zurich, Switzerland*

Dear Editor:

*Re: Israeli Response to Indian Earthquake*

On January 26, 2001 at 08:45, an earthquake took place in the Kutch region in the State of Gujarat, India. The quake came in two waves, and lasted more than 2 minutes, with the force of 7.9 on the Richter scale. The destruction was devastating. Entire cities were destroyed, entire neighborhoods were wiped out as houses collapsed. In the areas in which houses did not completely collapse, they

were not fit for living. Thus, entire cities became huge encampments made of tents and plastic sheets.

Forty-eight hours after the quake, on January 28, the Government of India approached the Government of Israel with a request for medical aid. Within 24 hours an Israel Defense Force (IDF) medical mission was organized. The mission consisted of a field hospital with some 100 persons, including doctors, nurses, paramedics, x-ray and laboratory technicians. Based on previous experience, the medical team included orthopedic surgeons, general surgeons, gynecologists, internal medicine specialists, and experts in infectious and tropical diseases. We thought that in the first days there would be mainly victims of trauma, and then there would be patients with the infectious diseases endemic to India, and in view of the destruction of the infrastructure, there would be a risk of an outbreak of epidemics.

The Indian Government located us at Bhuj, the central city in the Kutch district. In this city there had been a district hospital with 400 beds that collapsed completely on the patients and staff during the quake.

Within a few hours our field hospital was set up and started operating. And, indeed, the majority of cases were orthopedic. Among the many orthopedic patients there were also pregnant women who went into labor. The first delivery was of a premature baby girl weighing 950 grams. Since we came equipped with the proper medical equipment, this little baby's life was saved. Word of this birth spread through the local media, according to which the child was called Israela. During our stay there, we performed 55 operations, including 3 cesarean sections, and 13 babies were delivered.

Surprisingly, no epidemics broke out, and the incidence of infectious diseases was very low, with the exception of infected post-trauma wounds. There was one post trauma case of tetanus in an old woman that occurred one week after she had been wounded in the quake. Hopefully, this was

the only case that occurred. We discovered that the day after the earthquake, the Indian Army conducted a tetanus vaccination campaign, and this, together with the high vaccination coverage in the State of Gujarat, prevented more such cases.

During this time we observed the manner in which the local population coped with the aftermath of the quake. From them, we learnt an important lesson in helping one's neighbor. The level at which people helped each other was indeed awe inspiring. Priests and lay persons from all over India, and Indians from all part of the world, enlisted to help. Some came to help out at our hospital, either as medical personnel, or as translators. In the city itself, groups were formed to bring enormous quantities of food, and public kitchens were opened to serve food to the people. Bottled water was distributed by the government and private organizations. The facts that people had bottled water, properly prepared food, and the quake occurred in the dry season (the rainy season is in the summer), helped prevent outbreaks of food- and water- borne diseases.

Despite the widespread destruction and despite the high casualty rate - some 30,000 dead and many more wounded, we did not see scenes of despair. Bodies that were dug out of the ruins were immediately burned. People just continued to carry on their daily existence. Although people became destitute, they did not seem devastated. We asked the head of a monastery about the religious significance of the earthquake, whether it was regarded as a karmic punishment. He said that in his view the universe undergoes processes of building and destruction. Now there was destruction, but they would continue to build. This answer taught us much about the Indian philosophy of life, and the strength it gives the people to cope with such a devastating experience. We felt we came to help, but left having learnt an important lesson from them.

*Eli Schwartz  
Jerusalem, Israel*

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Dear Editor:

As host of your TRAVELMED list I seldom post to TRAVELMED except on list technical issues. I am taking the comments by David Freedman about the fact that travel medicine seldom makes it on the radar screen of travel reporters as an excuse for offering a suggestion.

It is not uncommon for interested groups to set up occasional training workshops for reporters. For example, the Carter Centre in Atlanta runs training workshops for reporting on mental health issues - to train reporters. I have seen similar efforts for improving the training of science reporters.

ISTM might consider experimenting with a modest training curriculum for travel writers, to be held as a one-day workshop in conjunction with the ISTM meetings. The curriculum could grow into something that could be farmed out for regional workshops, or it could start as a regional initiative and be brought to the ISTM meetings once it matures.

Lastly, ISTM, or groups within ISTM, might consider doing a survey of travel reporters/writers asking them if such a workshop would be useful and what it should cover. I would be interested in collaborating with any efforts in this area.

*Sam Lanfranco,*  
ISTM TRAVELMED ListHost/Administrator

Dear Editor:

I am very saddened that the New York Times and all its world wide readers will lose the insight, honesty, humor and integrity that Betsy Wade has brought to the Practical Traveler column and travel journalism for 600 plus articles over 14 years.

As an avid reader of her column it never ceased to amaze me how she “gets it right” - summing up big issues into sage advice that can be used by travelers and travel

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## Announcements

### Note from the Editors

A website is an ideal site to post large amounts of information, especially reference information requiring periodic updating.

We are initiating a new feature, **On the Web**. Our first posting is **Drugs and Vaccines for Pediatric Travelers: An Integrated Table**. This monumental work will be especially helpful to the many travel health professionals who deal mainly with adults but who also see pediatric travelers. The text, several very large tables, and the references will appear on the web site. The text of the article, without table and references, will appear in the next issue of the Journal of Travel Medicine (8/5). The tables will be updated, as necessary.

**Drugs and Vaccines for Pediatric Travelers: An Integrated Table** was compiled by Caroline S. Zeind of the Massachusetts College of Pharmacy, Boston, and Mary E. Wilson of the Mount Auburn Hospital, Cambridge, Massachusetts.

We hope this posting will be the first of many. Please contact us if you or someone you know has developed a similar compilation and is willing to share it will our membership.

*Charles D. Ericsson, MD, Editor, Journal of Travel Medicine*

*Karl Neumann, MD, International Society of Travel Medicine Web Editor*

### ISTM Listserve

This is a reminder for all new members as well as old members.

For those who want to electronically interact in a regular manner within the discipline of travel medicine TRAVELMED, the ISTM Listserv is available. This is an unmoderated discussion group restricted to ISTM mem-

bers that must be actively joined. It is not automatic with your membership.

To join: Send an e-mail message to: listserv@yorku.ca with the words “subscribe travelmed XXXXX XXXXX (type your own name where the X’s are)” in the body, not the subject line, of the message. Once accepted for membership, you will automatically receive further instructions from the server.

Further technical instructions as well as the TravelMed Charter (describes scope of allowable topics) are on the ISTM Website at www.istm.org. The most important thing to understand, once you have subscribed is that items (called postings) for dissemination to the entire group will then need to be sent to the e-mail address travelmed@yorku.ca. The listserv@yorku.ca address above is only for administrative commands to the computer.

At present over 400 ISTM members from over 30 countries participate in stimulating and sometimes lively discussion. We hope you will join too.

*David O. Freedman, MD*  
*Chair ISTM Electronic Communications*

### Impact Factor of the Journal of Travel Medicine

Many of you have asked about when Journal of Travel Medicine will have an impact factor. We have a hard answer in the communication below addressed to our JTM administrative assistant.

The people who calculate impact factors, ISI, require three full years of data for their calculations. Since ISI began covering “Journal of Travel Medicine” in 1999, it will first appear in the 2001 Journal Citation Reports, which will be published in 2002.

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professionals and keeping the travel industry (include travel medicine) on its toes. She is a true journalist - finding and focusing on facts and communicating them to the public in a clear, sensible way. She is not swayed or fooled by bias (and is quick to admit her own when it may exist on an issue) or influence.

And she has contributed to our dynamic and evolving field of travel health/medicine. Besides her many well written, fair and even handed articles on travel medicine topics over the years (from Lariam to travel med on the web), Betsy has been a supporter of ISTM and an active member (a member of the Public Education and Training Committee). She has attended many of the ISTM conferences and has always been in eager pursuit of the facts both in the lecture rooms and the hallways. Again, she comes to the conferences with a mission to understand the facts, the breaking news and subtleties and to share her knowledge and insight.

The ISTM and the field of travel medicine should be honored to have had the ear and interest of such a dedicated first-rate professional, and wonderful person, for so many years. I wish a friend and colleague the best of luck on her next adventures.

*Rebecca W. Acosta, RN, MPH*  
*Executive Director*  
*Traveler's Medical Service*  
*New York, NY*

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