



EuroTravNet

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European Travel and Tropical Medicine
Network of the *International Society of Travel
Medicine*
*European Centre for Disease Prevention and
Control Collaborative Network for Travel and
Tropical Medicine*



**MINUTES OF THE
2nd EUROTRAVNET ANNUAL MEETING
At the Bernhard-Nocht-Institute for Tropical Medicine (BNI),
Hamburg, Germany, May 26th, 2010**

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37. Dr Francisco Santos O Connor

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8h: Welcome

8h30: The Bernhard-Nocht-Institute for Tropical Medicine.

- **Rolf Horstmann, Director of the BNI** welcomed everyone to the Institute and the meeting.
- **GD. Burhard, The Clinical Department:** The department employs about 250 staff, 100 scientists. Main focuses are on Research (i. Molecular and Cellular Biology, ii. Clinical Research and iii. Epidemiology), Training (University training and PhD, for which they would like to have more international students), and thirdly Service e.g. KCCR in Kumasi in Ghana (Centre for Collaborative Research in Tropical Medicine).
- **Stepham Günther, Head of Virology Department of the L4 lab:** SG gave a description of the new building in which there are 2 technically independent laboratories in which 5 workers are allowed. They have gained permission for recombinant virus technology, which is required under specific German regulations. They have negative pressure labs and all air is filtered. Storage occurs in freezers of between -80 and -150 degrees, and not in liquid nitrogen like other labs. Only small animal models are used in this lab.

Current and future tasks of the EU BSL-4 lab include: basic and applied research, technical maintenance, training and access for Member States, long term commitment in endemic areas (WHO) and worldwide commitment to outbreak responses (WHO).

Diagnosing imported viral infections is also an important role of the centre. As such cases of lassa fever, yellow fever, Marburg and CCHF cases have been diagnosed, of which 5 cases were in travelers.

8h45: EuroTravNet core sites members and partners: All members of the meeting briefly introduced themselves.

9h: EuroTravNet: how does it work and how does it grow & Issues Concerning the New tender? Ph. Parola.

EuroTravNet works under a two year contract with ECDC which includes 3 Work Packages (WP):

WP 1: Secretariat and information management of the network

WP 2: Travel medicine resources review

WP 3: Support to ECDC's Epidemic Intelligence and Response activities

The contract, for administrative reasons became 18 months long and will run out in July 2010. The network is growing with more members and Core Sites, and also includes partners. Any ISTM member is welcome to the network provided they see patients post-travel and are willing to share information and respond to emails. Core Sites are contributing GeoSentinel sites. Currently EuroTravNet comprises of 50 Members, 15 Core Sites and 35 Network Members in 20 countries. Three extra Core Sites have recently joined EuroTravNet: Stockholm, Liverpool and Saint Mandé.

The EuroTravNet website has recently been updated with the help of Adam Plier (GeoSentinel). Documents are provided on the website for interested members. EuroTravNet continues to also

increase its web presence; with a page including links on the ECDC website and by appearing on the ISTM website. ISTM also ask EuroTravNet every 3 weeks if they have any new interesting informal news pieces or publications for the 'World Watch' section on their site. EuroTravNet also recently appeared in several travel medicine original research and review articles (Emerging Infectious Diseases, 2009; EuroSurveillance 2009; Clin Microbiol Infect 2010).

WP1 Update:

The first Annual Meeting was held in Stockholm in April 2009, with the first SC meeting. The second SC meeting was held in Verona in September 2009. It was emphasised that it is important that the expertise of members is maintained and any contacts of members are welcome to get in contact.

One key sub-task of WP1 include the lessons learnt from events and outbreaks response; this has been illustrated with the response to H1N1 and EuroTravNets role in the risk assessment.

Science Watch, a monthly update on significant publications or development regarding disease covered by the tender, is also part of WP1. They appear on the ECDC website. Please contact PP if you don't receive these updates. All members are welcome to propose articles that are of relevance for travel and tropical medicine and have public health importance, particularly for Europe. ECDC commented that it would be useful if critical comments were provided with the articles and comments to put the article in context.

WP2: PS to present next.

WP3 Update: EuroTravNet continues to support ECDC with an cell phone on call system. Most queries come via email. EuroTravNet also contribute to the ECDC Annual Threat report. This year the report was very complete and did not require many comments. The 5 threats were Q-fever in the Netherlands, Autochtonous malaria in Greece, West Nile Virus in Europe, *Legionella* related threats and Plague in Algeria.

Subtask 2 of WP3 is the participation in ECDC's epidemic intelligence meeting. The last 2010 example was a phone conference about the outbreak of Q-fever in The Netherlands.

Subtask 3 of WP3 is to provide ad hoc advice/guidance for risk assessment and risk communication. EuroTravNet is asked to share information but is not required to do this on a routine basis. Unusual cases that are "important or very suspicious" should be reported to ECDC. Two recent examples include imported Human African Trypanosomiasis in Europe in August 2009 and the increase in rabies in Northern Italy.

Subtask 4 of WP 3: EPIS, a platform for technical and risk assessment and risk communication in the form of internet forums to provide a place for experts to exchange views. This task is taking time, money and resources although it is hoped to be operational and running in the next year.

The EuroTravNet/GeoSentinel Platform: PP has the ability to review what is being reported into the GeoSentinel database by European core sites which he does at least once per week. There is also the functionality to see details about the patient and the reporting site. The GeoSentinel database is also used to search for outbreaks within Europe and to encourage sites to publish. Recent examples are imported dengue-3 in European travellers, identified in Marseille, Paris and Stockholm, and later published as a Rapid Communication by ECDC, and Chikungunya infection in returning travellers.

The GeoSentinel database has been used for data analysis purposes including the study in EID - Multicenter EuroTravNet GeoSentinel Study of Travel-related Infectious Diseases in Europe and more recently VF's study which is currently under review at BMC Infectious Diseases. The leading team for next year's study is S.Odolini, Brescia, Italy.

Other ongoing issues include **Specific Surveys**. These are used for collaborative work where desired.

The new tender: ECDC announced that they wanted to change the requirements of the contract, in order to be more in line with the current needs and activities of ECDC in travel medicine. As such the only way these changes could be incorporated into the contract was to develop a new tender. EuroTravNet has submitted its proposal and the outcome should be known within the next two weeks. The new tender will include a slightly increased budget of €180,000 in light of the new tasks (NOTE: the day after the meeting EuroTravNet Director received an email announcing that the EuroTravNet application for the new tender was successful!). The two new subtasks are:

1. Guidance on “Travel risks, precautions and vaccination requirements”

ECDC have clarified that in line with this task, European travellers need the most up to date information. That said if this information exists with other bodies such as NaTHNaC then links can be provided. The main task here is to provide travel medicine relevant information on existing ECDC disease fact sheets.

2. Travel health country information for travel within EU/EFTA.

Following this new proposal core sites have been asked if they want to participate on the new tasks should the tender be accepted. As such the proposed coordinating team is Gerd-Dieter Burchard, Francesco Castelli, Frank von Sonnenburg and Patricia Schlagenhauf who will be the overall coordinator for this new work package 2. All network members are welcome and encouraged to participate. It was emphasised that completion of these extra tasks does not mean EuroTravNet needs to reinvent the wheel and a lot of the work is already done by WHO, NaTHNaC etc. However it is an opportunity and important to be leading on it. Keeping the information up to date is also part of the tasks. It was stated that whilst other grants can be made for other projects for EuroTravNet it would not be appropriate to apply for additional funding for completion of these additional tasks.

9h30 : EuroTravnet Work Package 2: Travel medicine resources review: update of the work. P. Schlagenhauf.

PS began by thanking everyone who had contributed to the Inventory. The continuing challenge is the expansion of Europe, with the addition of new countries with potentially large numbers of travellers. With a population of > 500 million inhabitants, Europe is extremely diverse and non homogenous, producing barriers for travel medicine such as language barriers (>65 languages in Europe), heterogenous practitioners in various countries and cultural differences. However it also brings opportunities; well established historical institutions, individual approaches to travel medicine problems and networking opportunities. Europe is in fact the worldwide leader in outbound travel (475 million annually). Travel within Europe is becoming increasingly important as well (402 million annually). Europe also receives a large number of travellers (462 million annually) of which a large proportion are VFRs (30%).

WP2: Inventory of travel medicine resources

An electronic questionnaire was used to collect information about travel medicine resources in Europe by country. Over 1,200 Europeans accessed the survey with a full completion rate of 40%. The countries with the highest response rates were the UK, Germany and France. The largest number of responders were from the UK (27.9%). The only country for which a contact wasn't identified was Macedonia otherwise the inventory provides complete coverage for the EU and allied countries. DF commented that he has a contact in Macedonia.

The questionnaire allowed identification of:

- Major centres in travel medicine

- Yellow fever vaccination centres
- Migration medicine focussed centres
- Centres of expertise

It was reiterated that the Inventory is non commercial, is the property of ECDC and cannot be placed onto the website, although a summary will be placed on the site and feedback will be sent to everyone at this meeting. For specifics please contact PS.

Key Results:

- 14% of respondents give > 5,000 pre-travel health consultations, therefore the survey captured the main players in travel medicine.
- The most common type of travel health service offered was pre-travel consultations followed by yellow fever vaccination and post-travel consultations.
- National health system clinics were the most frequent deliverers of travel health services, probably influenced by the large number of UK based respondents. Specialist travel health practices and private practices then followed behind. Very few centres for migration medicine were identified.
- The majority of travellers were tourists followed by mixed tourists and migrants.
- The survey identified over 80 centres that were giving >1000 yellow fever vaccines annually. That said, a large proportion of centres stated they give no yellow fever vaccinations.
- Migration medicine was identified as a huge priority and is failing to receive the attention it needs. About 75% of responding centres offered no specific services for migrants.
- Research potential exists around imported diseases which continue to pose a threat to Europe.
- Much research has already been done throughout Europe providing networking opportunities for future projects.

In conclusion, the inventory has been successful with over 1,200 respondents. The survey is real time and response is growing. Using national websites and congress mailing lists, the target providers are being reached and services documented. It continues to be important to avoid duplication in navigating travel medicine in Europe. Other main players include WHO, ECDC, ISTM and WHO. There is however an under representation of new areas within the inventory so anybody with contacts are urged to get in touch. It is important that these areas are included as whilst they may not send as many travellers overseas, they are likely to receive a lot of travellers.

In addition to the questionnaire structured interviews, web searching and a review of pre-travel advice and travel medicine products provided important detail on the practice of travel medicine in Europe.

This work will be completed by the end of the year and will be published as a research paper. Thereafter, in the context of the new tender, the travel medicine inventory will be included in the WP1, as a continuing update.

10h: Travel related threats at ECDC. F Santos- O'Connor

ECDC plays a key role in monitoring worldwide health threats with importance to Europe. ECDC's mission is to identify, assess and communicate current and emerging health threats to human health from communicable diseases. Among other activities, ECDC does this by implementing epidemic intelligence activities including event and indicator (traditional public health surveillance) based surveillance. The ECDC does not undertake any risk management however as this is the responsibility of each Member State and the European Commission. The

process of Epidemic Intelligence follows a staged process: Signals > Events > Verified Events > Threats > Response. ECDC encourages EuroTravNet members to report signals (cases, outbreaks and events).

Core tools used by ECDC include: Threat Tracking Tool (TTT) and EPIS (Epidemic Intelligence System), TESSy (The European Surveillance System) and the Country Information System (CIS).

ECDC recognizes global travel as a major determinant in the emergence of infectious diseases, thus placing high importance on travel medicine. As such:

- The majority of monitored threats related to international means of transport (July 2005 - 2009) are accounted for by airplanes and ships (mainly cruise ships).
- The geo distribution of threats is worldwide, although many particularly cluster in tourist hotspots. At present ECDC does not provide advice on health issues for travelers but will do in the future.

ECDC monitors closely threats that:

- (a) May result in secondary transmission in Europe (e.g. dengue) with potential for multiple generations of spread. The majority in the last period were due to tuberculosis. 92 threats were reported with limited spread potential, of which the majority were due to cholera. Vaccine preventable diseases are also included in this group, of which measles represented the largest number of threats.
- (b) May generate secondary cases if not diagnosed quickly e.g. VHF.

ECDC also monitors threats that may need expert advice from travel and tropical medicine specialists. They also play a role in the risk assessment of the EU response. Between July 2005 and end of 2009, ECDC monitored 36 threats related to mass gatherings. ECDC and EuroTravNet worked together last year on the Hajj pilgrimage in relation to H1N1.

ECDC also provides support to Member States when facing public health risks using their outbreak assistance teams (OAT). EuroTravNet members are welcome to participate in these teams, but people need to be available quickly. Usually these teams respond to events in Europe although they do sometimes collaborate with WHO elsewhere in the world.

Examples of threat assessments which required collaboration from travel medicine experts:

1. Q-fever in the Netherlands - EuroTravNet provided contacts that ECDC may not have had.
2. Autochthonous *P.vivax* malaria in Greece - two imported cases by immigrants in summer 2009 causing secondary cases.
3. Autochthonous *P.vivax* malaria in Italy: In November 2009 a case was reported in Rome which turned out to be a relapse from an infection acquired in an endemic country.
4. WNV in Europe - Increasing numbers have been reported in Europe in the last decade, although it's not clear whether this is due to changing epidemiology or increased surveillance. Continued close monitoring is required. It is important to increase awareness amongst clinicians so that new cases are rapidly diagnosed.
5. Plague in Algeria - A EuroTravNet collaborator and expert took part in the investigation.

FSC stated that the reason the contract has been called to tender again is not because ECDC were unhappy with the work that EuroTravNet are doing but rather that they have been given additional money for extra tasks which have had to be put together with the old contract to form a new one.

Conclusions:

- Many health threats monitored by ECDC correspond to diseases related to travel medicine.
- ECDC has benefited from advice and guidance for risk assessment and risk communication from tropical and travel medicine experts.

- New features where travel medicine experts may contribute to ECDC's mission have been identified and new collaboration is intended as an extension of the existing EuroTravNet contract.

10h45: EuroTravNet Surveillance: new tools and news from GeoSentinel. D. Freedman.

The GeoSentinel Surveillance Network is a worldwide communications and data collection network of travel/tropical medicine clinics. Three key functions of the GeoSentinel Network are:

1. Surveillance - Response
2. Surveillance - Ongoing trends
3. Analysis of morbidity and estimating risk.

The network is funded by the CDC in 5 year cycles. July 2010 is the last year in the most recent 5 year cycle, therefore they will need to reapply for funding this year.

The GeoSentinel network comprises of approximately 50 sites worldwide and will remain at this number with the current level of funding. Three new sites of interest are those in Vancouver, Cape Town and the site in Latin America (just outside Mexico, following the H1N1 outbreak).

The data set is large, with over 119,000 records in March 2010, and growing, particularly in the last 3 years, thus the data is quite recent. Minimal clinical data is collected, the focus is on where travelled, when and what diagnosis for each patient.

Through GeoSentinel, PP at EuroTravNet has access to a report generator to allow data to be downloaded from all the European sites. PP can be contacted should members require information from the GeoSentinel database. Likewise PP can email DF for queries from all GeoSentinel sites.

A significant number of publications have been produced using the GeoSentinel database, including ProMED-mail postings.

GeoSentinel is also expanding its mapping capacity with Health Map. These maps are the main way for other sites to find out what's being diagnosed at other sites. The maps display individuals patients from the past 4 months, although reporting sites are not displayed. Any GeoSentinel site has access to this map. The database has the ability to very accurately record place of exposure and does this in real time. The option of an email update is soon to be offered to sites to avoid logging on. Mobile technologies are also being explored.

Final diagnoses are predominately used, and are used for Health Map along with Alarming diagnoses. During the H1N1 pandemic sites were asked to report it as a final diagnosis before confirmation. In other situations it is possible to send informal emails to GeoSentinel before reporting an Alarming diagnosis.

11h: Travel and migration associated infectious diseases morbidity in Europe, 2008. V. Field

Travellers who presented (clinic visit date) from 1st January - 31st December 2008 to a EuroTravNet core site, during or after travel, and entered into the GeoSentinel database were included in the study, which came to approximately 7,000 patients. There were 12 core sites at the time of the study.

Measures of proportionate morbidity (number of cases of a specific diagnosis compared to all cases of ill returned travellers seen during the same time period) were used and a sub-analysis compared travellers who were likely “Exposed in Europe” to “All other travellers” was also undertaken.

Results: The largest number of returned travellers were from Sub-Saharan Africa. Febrile systemic illness or gastro-intestinal illnesses when grouped were the top diagnoses.

Gastrointestinal illnesses accounted for 33% of diagnoses, of which acute diarrhoea was the most common.

Febrile systemic illnesses accounted for 20% of diagnoses, the majority of which were accounted for by malaria. 12 cases of severe complicated malaria were reported with one being fatal. One case of *P.falciparum* malaria was diagnosed in a tourist returned from Great Exuma, Bahamas where malaria transmission does not normally occur. Another case was also reported in a tourist returned from Punta Cana, Dominican Republic, where European guidelines vary for chemoprophylaxis. Similarly 3 cases were reported from India where guidelines for prophylaxis also vary. Additionally malaria within Europe still poses a threat with climate change.

In addition, Dengue was diagnosed in 131 patients, including one death and Chikungunya virus in 12 patients. Thus the presence of *A.albopictus* in areas in Europe makes early detection of imported cases of Chikungunya essential.

Dermatological conditions accounted for 12% of diagnoses, most of which were due to bacterial infections, arthropod bites or cutaneous larva migrans. 80 animal bites were also reported.

Respiratory illnesses accounted for 8% of diagnoses, including 104 influenza-like diagnoses. A concerning number of *M.tuberculosis* were diagnoses (112) which were mostly in immigrants, thus representing a concern for European public health authorities.

166 cases of potentially vaccine preventable diseases were reported, thus the pre-travel consultation also represents an opportunity to review routine schedule vaccinations.

Chagas disease was diagnosed in 94 patients, of which the majority were exposed in Bolivia and imported into Spain. Chagas disease could represent an emerging public health problem in Europe, especially since the infection can be transmitted in non-endemic countries.

In the sub-group analysis, those exposed in Europe were more likely to be born in Europe, currently live in Europe, be younger, not seek pre-travel advice, travel for shorter trips and be VFRs or tourists. In terms of diagnoses the most common were gastro-intestinal illnesses (16.9%), respiratory illnesses (14%) and dermatological conditions (7.9%). Eastern Europe travel to Western Europe was associated more with gastro-intestinal illness and respiratory illness, whereas Western Europe travel to Eastern Europe was associated with more cases of potentially vaccine preventable illness and acute sexually transmitted infections.

It was concluded that pre-travel advice is therefore recommended for travel within Europe, which is clearly without risk to health.

14h: Status of YF mapping by WHO, David Hill

In 2008, WHO called a consultation was called with the goal of reviewing the criteria for inclusion/removal of countries and/or areas for yellow fever. The two driving forces were the vaccine safety issues with yellow fever and its changing epidemiology. The outcomes were as follows:

1. Evidence: The working group used a series of historical and serology data of case detection in humans and non-human primates, along with geographical data.
2. Yellow Fever Risk Categories: This evidence was used to produce 4 categories of risk.
3. Maps: The agreed risk categories were then transferred to maps, which were then agreed by both WHO and CDC. These maps have also been transferred to Vaccination Maps to increase clarity for practitioners, which include high risk areas, transitional areas and low risk areas.

The outcomes have implications on the International Health Regulations since under the new guidance countries, the wording has been altered so to not trigger vaccination in certain circumstances.

The outcomes will be communicated in April-May 2011. Existing guidelines apply in the interim.

Gilles Pomerol: World Health Organization

It was reported that the WHO are much more interested in travel health now, particularly the public health aspects such as controlling the spread of communicable diseases. They also serve travellers through the WHO book which at present is the global reference for yellow fever maps. The travel health department is very small within WHO but they use the current competences of the WHO and partners such as EuroTravNet. It was noted that as the WHO they have to remain representative of all member states and serve everyone, therefore the book can't be as comprehensive. They are also aware that there is lots of duplication which they are keen to avoid and thus are ready to collaborate where possible, playing the role of facilitator. One limitation however is that any new recommendations have to be approved by member states and can thus take time.

14h15: Chagas disease in Latin American migrants. A European challenge. R. López-Vélez JA Perez Molina

Europe is faced with ~ 70 million migrants, of which a large proportion are from Latin America. Spain in particular has been faced with a huge amount of migrants in the past 5 years (5 million). Chagas disease has spread from Latin America as a consequence of migration causing a world health problem: most Latin Americans are infected with *T. cruzi* in childhood, and many of the migrants are now at the age of the first manifestations of disease. In Spain 17,400 cases are estimated. 3,335 cases have been reported to date in Spain, which is significantly more than the majority of other European countries. Most of these cases have been in Madrid. Vertical transmission cases and transmission through blood transfusion have been reported. It was emphasized that Chagas disease is a chronic disease, with no test of cure and there is a lot of work to be done.

The number of Chagas cardiomyopathies are predicted to be anywhere in between 5-29,000 cases, thus Spain is facing a huge medical problem.

In a prospective observational study Latin America immigrants diagnosed with *T. cruzi* infection in Hospital Ramon y Cajal in Madrid were treated and followed up on an outpatient basis for 2 years. The aim of the study was to obtain some estimate of the prevalence, an idea of the clinical-epidemiological characteristics and to collect preliminary data on response and tolerance to treatment. The majority of cases were from Bolivia and 67.5% were female. 83.5% recalled seeing a vector and 59% had a relative with Chagas disease.

Clinical data was collected on 252 patients: visceral involvement was seen in 22.2% of patients. 195 patients received treatment but 91 did not complete treatment due to secondary effects. However all patients had negative PCR results.

Mobile public health teams are working in Madrid to provide rapid tests in situ and health education at public days such as Dia de Bolivia. The national guidelines in Spain specify

compulsory testing for Chagas disease in any donor with risk. Screening in pregnant women is also compulsory in some regions. Treatment is provided for free by WHO.

14h45: Research and collaborative studies within EuroTravNet.

- **Molecular tools to diagnose Acute Schistosomiasis. GD. Burchard**

Detection of cell free parasite DNA for acute schistosomiasis has been developed by Dominique Wichmann. PCR is completed here at the Institute. Samples are wanted for research, particularly for Katayama syndrome, in order to evaluate this previously unevaluated detection technique. 10 samples have been received so far. 5ml of EDTA-Blood and 3,5ml of serums are required for samples. Testing will be provided free of charge.

- **Diagnosis of Rickettsioses at the WHO coll center in Marseille. P. Parola**

For patients with suspected Rickettsioses samples can be sent to this WHO Collaborating Centre where serology and PCR will be provided. Samples can be sent by post, with a completed form. It is advised to check the legal requirements of posting samples in home countries, although there are no problems with receiving samples in France.

- **ENIVD Survey of Dengue and Chikungunya P.Parola presenting an ENIVD proposal**

European Network for Diagnostics of 'Imported Viral Diseases' (ENIVD). Reference labs are provided to make the diagnoses of Chikungunya and Dengue. If sites want to participate then samples tubes can be sent. Anyone participating in the survey can negotiate how they are acknowledged in the survey write up.

- **StaphTrav: A network for surveillance of imported *S.aureus*. P.Zanger**

P.Zanger introduced Tuebinger University which hosts a travel clinic, diagnostic lab and carries out research.

Current trends show a worldwide increase in *S.aureus* infection. Prescription data shows a doubling of cases. Many people with complicated *S.aureus* infection will have a history of travel and this is not receiving enough attention. Further attention needs to be placed on determining the role of travelling populations on spread and resistance and also transmission to non-travellers.

StaphTrav is a surveillance network which would like to be embedded into EuroTravNet with the aim of finding out to what extent importation contributes to: the spread of new strains, existing strains and what the trends are of regional prevalences. In order for diagnosis to be made, a swab is required from patients with a series of anonymised questions. Cell culture and PCR will then be provided. A bacteriology lab and typing technologies have been established, and they are open for collaboration. The network provides:

- Quick distribution of results
- Communicates findings to stakeholders and the scientific community
- Quarterly reports
- Application for funding

In summary it was concluded that *S.aureus* is of considerable public health importance with significant morbidity and associated cost. It also causes fatal cases in the young and healthy. Community acquired *S.aureus* poses a threat, being more virulent and with the potential to move into hospitals.

15h 30: Conclusions. P. Parola and F. Santos

PP concluded the meeting by stating that 2011 is very much dependant on the results of the new tender.

We know now that the new contract is awarded to EuroTravNet!

The next Annual Meeting will be held in April 2011.

Southern and/or Eastern Europe countries were proposed as possibilities.

Please email secretariat@eurotravnet.eu with suggestions. The only requirement is that the venue can be provided free of charge. A date for the diary is CISTM12 which will take place 8 - 12 May 2011 in Boston.

Gert-Dieter Burchard was thanked for his role in organising this meeting !