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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 EUROTRAVNET ANNUAL MEETING IN BUCHAREST APRIL 4th, 2011

Clinical Hospital of Infectious and Tropical Diseases "Dr. V. Babes"

Spitalul clinic de boli infectioase si tropicale "dr. Victor Babes"

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Welcome (by Philippe Prola, Corneliu Papescu and Simin- Aysel Florescu)

PP and CP welcome all the people attending the ETN annual meeting.

Prof. Florescu gives an overlook about travel medicine and tropical diseases in Romania.

Romania has some geographical particularities: it has a temperate climate, the main mountains are the Carpathian, while the main water basins are represented by the Black Sea and the Danube delta. The major local pathologies are: hepatitis A, B, C, influenza, measles (the last measles outbreak was registered in 2004-2005 due to a vaccination gap), West Nile encephalitis (last outbreak in 1996), meningococcal meningitis, leptospirosis, tick borne diseases, trichinelosis.

Hepatitis A has decreased from 100 cases to around 0 in recent years, and nowadays is present especially just in two districts in the heart of the country. Hepatitis B is decreasing too. Meningococcal meningitis is not very frequent in the country and it is decreasing too, though type B is the most common. In 1996 Romania faced a major outbreak of Western Nile (393 cases recorded) in the Eastern part of the country, then very few cases were registered, except for some picks in 1997 and 2001 in the South-East of Romania, and in 2010 with 57 cases recorded all around the country. Tick borne disease is mainly present in the South Eastern part of the country, while trichinelosis incidence is decreasing thanks to more accurate controls on meats, especially during Christmas time, when people eat a higher quantity of pork meat. In 2005 a pick of leptospirosis incidence was recorded, but it is now decreasing, thanks to an educational policy activity conducted towards the population.

Concerning the national immunization program, Romania provides major vaccines. Hepatitis B vaccine was introduced in 1995, but vaccines for Hepatitis A, varicella, rotavirus, and pneumococcal virus are available too. With particular reference to the travel vaccination, Romania provides the classical vaccinations for travelers, especially yellow fever vaccine, while cholera vaccine is available just in few center of the country. For the antimalaria prophylaxis mefloquine, doxycyline and chloroquine are available in Romania, but just in specialized centers with the Ministry of Health approval, while Malarone is not available.

The Clinic Hospital of Infectious and Tropical Diseases "Dr. V. Babes" (*Spitalul Clinic de boli infectioase si tropicale "Dr. Victor Babes"*) was founded in 1976. It has 450 beds (among these 111 for HIV/AIDS patients and 154 for TB infection) and some laboratories for virology, bacteriology, and parasitology.

Teaching activities are conducted for 150 students per year.

Travel medicine is of major concern for the Clinic, though vaccines are not available in the hospital and therefore they can only be suggested to travelers.

Concerning the clinical activity, in the last 11 years the hospital had 91 malaria cases (80 coming from Africa), and 14 cases of visceral leishmaniasis, which mainly affects Rumanian people working in Spain, Italy, Greece.

Romania registered local malaria cases until 1968, then it was eradicated thanks especially to the temperate climate, and nowadays the hospitals has just imported resident cases of malaria, which is treated through quinine and artemisia especially.

Leishmaniasis cases are nowadays recorded around the Mediterranean Sea, though it is expected in the future in Romania too, due to the global warming, that can allow the disease to spread into the country, and indeed some leishmaniasis cases are already recorded in the South part of the country.

Other minor diseases recorded are the following: amebiasis, larva migrans from Jamaica and Africa, lymphatic filariasis from India, one case of cholera from India too, and one case of schistosomiasis from Ethiopia.

The main challenges that Romania has to face are the following: firstly, medications are difficult to obtain because of the lack of legislation regarding the import authorization. A lot of paper work is needed to obtain authorization from the central State to buy some drugs, and some of them are available just in specific centers. Secondly, training of health professionals has been begun just in recent years, especially concerning travel medicine. Finally, global warming is of major concern because it may lead to the re-emergence of eradicated diseases.There are just very sporadic cases of rabies in rural areas, and however prophylaxis is available.

There are not statistical available data concerning TB at the moment, though it may be said that it is often associated in HIV patients (especially in the elder population), and however the number of cases is decreasing thanks to the fact that patients are learning how to take drugs properly and, moreover, drugs are for free.

Romania is also facing a lot of HIV children cases. It is reasonable to think that many unknown HIV children cases are present in the country.

Romania does not have a high percentage of immigrant people. The immigrant population comes especially from China, India, Pakistan and South Indonesia.

Costanta Hospital (by Stela Halichidis)

Stela Halichidis is the manager of the Costanta Hospital in Romania, on the shores of the Black Sea.

With reference to the travel medicine, the Costanta Hospital presents similar conditions as those in Bucharest, though it offers specific programs to face those diseases that can show up due to the particular characteristics of the city.

The city has a Faculty of Medicine, and every summer the hospital organizes summer schools in collaboration with national and international experts with many sessions concerning the travel medicine. Travel medicine is, in fact, a very important branch in Costanta Hospital, since many sailors work in the city, due to the fact that the Black Sea represents a favorable communication channel to both the East and the West, and therefore many cases come from abroad.

The main detectable diseases are the following: food poisons (food is not very well cooked especially during the summer), cholera from Turkey, dysentery, malaria, hepatitis, enterocholitis, measles, amebiasis, pneumonia, influenza, Mediterranean fever, typhoid fever, leptospirosis, HIV infection especially in sailors due above all to sexual behaviors, animal bites (rabies, due to the fact that there are a lot of dogs without master around), tetanus. Encephalitis cases are instead no more registered.

ETN overview and the new contract (by Philippe Parola)

The collaboration between ETN and ECDC started with a 2 year framework contract. In 2010 new tasks were added and a new framework contract for 2 years with a possible 2 year extension was signed.

ETN has a website that includes current and updated activities, and a section where people can find information on how to join the network, but at the same time ETN is advertised on the ECDC website and in the World Watch section of the ISTM too. PP encourages the members of the network to submit some cases or data to EuroSurveillance (time of publishing: 1 week, if accepted), instead of PromEd. At the end ProMed highlight news published in EuroSurveillance.

At the present moment the network is composed by 55 members. The last members adhering to ETN include members from Central and Eastern Europe (Czech Republic, Milan in Italy, Russia, Denmark). Among the 55 members ETN is composed also by 16 core sites (reporting sites for the GeoSentinel system), among these the institute based in Porto, which has been the last one to join the network. ETN is therefore composed by 55 network members in 22 different countries.

One of the goals pursued by the network is to attract more interactive members and at the same time to attract them especially from Eastern Europe.

ETN is composed by 3 work packages (WP), for a total budget of € 180,000.

WP1

WP1 is based in Marseille and it is responsible for the overall administration, the financial aspects, the overall management of the network, and the elaboration and mailing of the Science Watch to all the members of the network.

Science Watch is the result of one of the requests put forward by the ECDC for the collaboration with ETN. It is composed by 5 selected literature articles and a comment ("ECDC comment", that according to FS will be mixed with "Public health significance" section of the comments) to each one. The aim of this publication is to favor the exchange of comments on different articles concerning travel medicine, migration medicine, infectious diseases and tropical diseases, relevant to Europe. Science Watch is distributed every month to all the members, but it is also published on ETN and ECDC's websites. Since last July a rotation among some sites was introduced to choose the articles and to prepare the issue. The rotation had a double aim: to split the work overload, and to propose articles of different interest and topics, since each group of people collaborating in the realization of the issue is specialized in different sectors, so to become more exhaustive towards the readers. Everyone can freely collaborate to the preparation of the issue by suggesting articles that can be of interest for this activity and by commenting the articles published. The key element of Science Watch is the ECDC comment part, even if it is made just by a couple of sentences, since it leads to a critical reading of the articles.

WP2

WP2 is responsible for the guidance on travel risk and for the precautions and vaccination requirements. It has two main tasks: (1) to update the diseases fact sheets of the ECDC concerning the travel medicine issues in Europe, (2) to update the country fact sheets published on the ECDC website concerning the travel medicine.

Each member of the network can freely join the working groups and asks for specific questions.

WP3

ETN may participate in the ECDC annual threat report, since it is possible that ECDC will ask ETN to comment on some parts of it.

The working group takes part to the epidemic intelligence meetings that can be organized concerning some important diseases outbreaks (e.g. H1N1 influenza). Moreover, the group may deliver *ad hoc* advices or guidance for risk assessment and risk communication, especially through the alerts system, and it may be asked to take part to *ad hoc* teams set up to face some specific crisis (e.g. earthquake in Haiti).

One of the advantages of the group is to have access to the GeoSentinel platform, which is a very useful tool to use. ETN has the possibility to download the data included in the database once a year.

The ETN Health Maps are also a good tool to use and to explore to obtain information. All the members may accede to the maps, and the "healthmap update" instrument has recently been introduced: people receive an automatic daily alert about what it has been added. PP

will send everyone the information on how to filter the data, so that users can more easily accede to the information they need.

One of the problems that ETN has with the Health Maps is represented by the delay between the patient's visit and the entering of data in the database.

Data analysis is an opportunity to work on database and to publish articles, adding for example among the authors a junior who actively took part to the data analysis (as it happened, for example, with the last papers produced). Many papers coming from this activity are reckoned as highly read. For the year 2010 it is difficult to provide highly original data again, therefore a short paper with a specific focus or analysis of some trends may be published.

Specific surveys may be proposed by ECDC or any member of the network. Comments and contributions are also welcomed.

PG is in charge of the WP3, but, as in the previous groups, everyone who would like to join is welcomed.

The future of ETN (By Philippe Parola)

There are no guaranties that the contract with ECDC will be renewed in 2012, therefore ETN might try to apply to the European calls.

Several consortium (Marseille, Spain, Paris) have approached ETN in order to apply FP7 on dengue and be in charge of a workpackage on imported cases travelers. PP could not sign, since ETN is a network and not an institution and the goal of such package was supposed to be more on virological and genetics aspects.

In the Barcelona meeting, a whole session concerning travel medicine has been scheduled, and PP is going to give a presentation on ETN.

Moreover, GeoSentinel asked ETN if there is someone among the core site directors, who would like to take a position as GeoSentinel European Project Director. Some people are interested, and at the end of the current year or next year ETN might have some updates regarding this point.

PP informs that Marseille may host a junior (young specialist) resident from May for 6 months. A basic knowledge of the French language is required.

Update on WP2 (By Patricia Schlagenhauf)

PS informs that the analysis of the data filled in the inventory during the former WP2 is ongoing. All data are however confidential, since the inventory is ECDC's property, and PS is the only one having the password. PS reports that 58 people spontaneously joined and updated data during the last months. The ongoing inventory has a total of about 1250 clinics/individuals, among these some major centers for travel medicine were identified and they will be asked to join the network. Cross tables may be used to do different analyses, and when they will be concluded, a report will be published on the website and sent to all the people who took part to the survey, though their names will not appear in the report, as agreed in principle. Whoever would need a specific contact in a specific country may, therefore, ask PP or PS.

A research paper with an analysis of the inventory is in preparation and once published this will also be available on the ETN website.

PS suggests that migration medicine would need more emphasis, since within Europe there are 402 millions people moving yearly and 462 millions arrivals in Europe, half of them for leisure (53%), 17% for business and 30% VFR.

FvS stated that it would be useful to have public access to the data – however PS emphasized that the respondents were assured of confidentiality and this must be respected. Furthermore, ECDC may ultimately use the information in the inventory for mailing lists. The information gathered in the inventory is not for commercial use. An inventory on travel medicine was done 10-15 years ago by Scotland and a report was drafted, but at the end the work was lost and no one had access to the data. FvS affirms that ETN and ECDC should find a way for avoiding loosing data and all the work done. Moreover, the group would need some feedback from ECDC in order to understand if the inventory responded to ECDC's expectations. FS will propose a brainstorming within the ECDC in order to try to understand how data might be better used. ECDC wanted at first an overall overview in Europe, but confidentiality, data protection and conflict of interest issues prevent ECDC from making data accessible to the mass public, though the results without any disclosure of personal data will be made accessible.

PS explains that the new WP has the task to update the disease fact sheets and the country fact sheets of the ECDC. The details needed for the diseases fact sheets are the following: (1) prevention, in particular describing "at risk" group; (2) describe geographical area of risk and variation in risk, season, behavioral risk factors, advice for pregnant women, etc. Health professionals are the targets of the fact sheets and they can freely have access to the information. ECDC may ask to write something for the travelers too in the future. As reference to the country fact sheets, the 27 EU (including overseas territories) plus EEA/EFTA countries need to be addressed. Each sheet will contain a brief discussion of the location of the country, the profile of the main diseases, maps, a table with information on local diseases, risk within the country with a link to the local epidemiological information. The local epidemiological information will be in most of the cases in the local language (except for those countries having the link in English too) and this raised a number of concerns since the links might not be understandable by everyone however use of links in the local language is specifically requested by ECDC. The name of the diseases in each of the country fact sheets will have also a link to the ECDC disease fact sheets. All this information is focused on pre-travel rather than post-travel advices. No information is needed on diseases without borders (e.g. influenza). All the fact sheets should be made in accordance with the ECDC mandate and working groups are encouraged to work closely with ECDC.A standardization of the words used may also be adopted (e.g. establish a common meaning for what "low" or "high" risk might mean). Brescia, Hamburg, Munich and Zürich have all provided their template "disease fact sheets " on schedule for year 1) of the contract and these draft documents now need to be refined and completed in association with ECDC.

Travel and migration associated infectious diseases morbidity in Europe, 2009 (By Francesco Castelli)

FC presents the 2009 data work, which was submitted to CMI, which still has to give a feedback.

12 sites took part to the work, which follows the paper coordinated by Vanessa Field and published recently on BMC infectious disease.

A total of 6392 patients were seen at EuroTravNet core sites in 2009, compared to 6957 in 2008. The most frequent area of exposure was Sub-Saharan Africa. Compared to 2008 there was a marked increase in travelers exposed in North America and Western Europe. Respiratory illnesses, in particular pandemic A(H1N1) influenza, flu-like syndromes and tuberculosis, were also observed more frequently. A significant increase in reported dengue cases in 2009 compared to 2008 was observed (n=172, 2.7% versus n= 131, 1.90%) (p=0.002). This increase was mostly due to the increased number of dengue cases observed ion Amsterdam and Oslo. Malaria and Chikungunya cases were also reported more frequently than in the previous year, highlighting the potential risk for introduction of these diseases in Europe where competent vectors are present. Chagas infections were reported less often than in 2008, probably due to (i) a cohort effect of cases screened in 2008 and (ii) the return of migrants to their country of origin due to the economic crisis

An increased in the TB cases number was also recorded due to newly arrived migrants especially from Pakistan and India in Brescia. HIV is present especially in migrants, though it cannot be excluded that the infection was local (Europe). Concerning the number of deaths, it is legitimate to think that a number of deaths are not reported by the centers.

The limitations of the study are presented (ample range of contribution among centers, different site/specific contribution by year, short observation period, etc.). However, the aim of the work was to say something original about 2009, but not to be completely exhaustive. The correlation between these data and those that ECDC may be object of further investigations.

Web conference with David Freedman

DF joined the meeting through a brief web conference.

DF states that GeoSentinel is working on the application to get a renewal of its 5 year grant coming from the US CDC. Migrants will be of particular interest. DF commented the healthmap update that are received by all sites, members as well as ECDC and the possibility to filter the data. GeoSentinel will let know soon some news concerning the European Director position creation for the next period. Updated on the new changes occurring within the ECDC's structure, DF proposed to invite ECDC to the meeting in Boston in May 2011 to present the geosentinel platform.

ECDC CHANGES and EPIS - Epidemic Intelligence Information System (by Francisco Santos)

Since last Friday all the ECDC's structure has been re-organised. FS will investigate on how ETN expertise and aims may match ECDC aims and needs. The new senior manager in charge of ETN collaboration and contract is Prof. Karl Ekdahl.

Travel medicine project in the new structure will be closer to the idea of preparedness and capacity building in Europe, where travel medicine related areas such as migration medicine and training may become important.

Concerning EPIS, FS explains that it is a system of connection of people working on the same diseases provided by ECDC. It is a real-time international platform through which a network

of experts can rapidly share information and data working together in a fully transparent way and diminishing the number of emails that people send and receive to reach the same goals. EPIS has different functionalities, among these, *ad hoc* forums, restricted areas, alert system, etc. Some sections of the platform are already active and may be accessible in the future to reference centres too, though there is still a lot of work ahead. Nevertheless, PP states that ETN members already exchange e-mails pretty easily, and therefore EPIS would not be such an useful tool, and by consequence money could be saved avoiding to set up the platform for the specific ENT use. However, experts from ETN would be happy to join any discussion using EPIS, when requested by ECDC.

Tropical and Travel Medicine in Czech Republic (By Frantisek Stejskal)

FrS explains that there are different Universities and Infectious Diseases Departments throughout the country (around 90 places)

Information in Czech Republic concerning travel medicine may be obtained through the Surveillance System of the National System of Public Health and the Surveillance of the National Reference Laboratories.

Cases of chik, typhoid fever, malaria and dengue can be recorded in the country, though among the 166 cases of malaria (1996-2010), the majority are caused by *P.falciparum* rather than *P.vivax* (the opposite than in the past). 39 cases of amebiasis have been recorded in the country and all are autochthonous cases, so as the giardiasis, which is also mainly autochthonous.

The Department of Infectious Diseases in Prague (Bulovka University Hospital) counts 170 beds, but there are no TB patients and STI cases (there are in Respiratory diseases and Dermatology units, respectively). From January 2005 to July 2008, 214 patients with fever in travelers, most of them coming from Africa and Southeast Asia (tourist destinations), were recorded.

In the study period 2005-2010, 41 patients with dengue and 8 with chik were hospitalized. The majority of the dengue patients were coming from South Asia, while 6 from the Caribbean or South America. The Chik cases were coming prevalently from Mauritius, Maldives, India, Myanmar, Malaysia.

The Bulovka University Hospital is a teaching center for Tropical Medicine and Medical Parasitology too, and it shares a strong collaboration with the Itibo Health Center (Western Kenya), especially in the following fields: delivery, basic diagnostic, serological tests, small surgery, stomatology.

International travel and health 2011 (by Gilles Poumerol)

WHO is going to publish the “International travel and health 2011” paper, which will be available next week. 50 experts contributed to the work. Chapter 6 on travel diseases preventable by vaccination has been revised, and an update on vaccine, HIV/AIDS in travelers, malaria and prevention, maps on infectious and tropical diseases was added. Moreover, the report included a country list which indicates the vaccines required by each country and those recommended by WHO. The report contains a focus on yellow fever.

GP adds that if someone is available to collaborate to contribute to some part of the book is welcomed, as people who would like to volunteer in translating the report in the following languages, in which the report will be published: Spanish, Russian, English, Portuguese, Italian, Chinese. People interested in these activities may contact Gill at poumerolg@who.int

Chapter 6, annex 1, maps, and the country list can be download free of charge, while the whole report can be download for US$ 10 or ordered and bought for US$ 30 dollars on www.who.int/iht.

Different opinions emerged concerning the cost of the report: some argue that it should be accessible free of charge to everyone, other argue that family MD may be not keen to pay US$ 10 to look for the information they need. On the contrary other people affirm that the most important parts of the report are free of charge and that US$ 10 is not that much, taking into consideration the financial cuts that WHO is facing. Gilles told that he will consider these comments when back at WHO

Air routes for disinsection (by Gilles Poumerol)

GP informs that WHO is working on new regulations on disinsection of the air routes, since many concerns have been raised in the last period concerning the consequences that pyrethroid aerosol sprays can have on flight crews and frequent flyers.

Final results of YF risk mapping by WHO (by David Hill)

In 2008 WHO asked a consultation for yellow fever (YF) with the aim to review the criteria for inclusion or removal of countries from the list of YF transmission.

The evidence used for the review were the following: human and not human primates, human serology prior to YF vaccination, vegetation and altitude, YF vaccination coverage. Three categories of risk were defined: endemic, transnational, low potential for exposure. Endemic (e.g. Nigeria) means that there is stable YF transmission within the country, transnational (e.g. Paraguay) means that there are areas bordering endemic zones with periodic evidence of transmission, low potential risk (e.g. Tanzania) indicates no human documented cases of YF, even though YF vectors are present in non-human primate hosts. No risk was considered for a transit of 12 hours or less in international airports, although in an endemic country. Each country was, therefore, evaluated on the basis of these criteria, and by consequence different areas were detected. Through the new recommendations changes in the countries’ status occurred: e.g. Tanzania, which was considered endemic up to this new risk mapping, is now considered a low potential country for YF exposure.

WHO recommends YF vaccination in endemic or transitional countries, while it is not recommended in low potential for exposure countries, except for prolonged, rural, extensive mosquito exposure. Vaccination is not either recommended for no risk countries.

Applying the old International Health Regulation, some countries used to require YF vaccination for people coming from low risk countries. However with the new regulations, low potential for exposure countries (former low risk countries) will not appear in annex 1 anymore, and therefore they will not appear in the list of those countries for which YF vaccine was recommended or required. Member States have, therefore, to review their YF requirements, and all changes have to be reported in new vaccination maps, in the WHO ITH 2011, and in the CDC Year book 2012.

DH states that this was robust process, where the best available evidences were used, transparency in decision making was applied, and globally agreed risk categorizations were achieved.

Research and collaborative studies with EuroTravNet

Artesunate vs quinine for complicated malaria in Europe - "Equamat" (By Jakob Cramer)

In 2005 Seaquamat (South Asian Quinine Artesunate Malaria Trail), and in 2010 Aquamat (Africa Quinine Artesunate Malaria Trail) were performed.

The results coming from from Seaquamat and Aquamat are here described: with reference to validity no truly blinded RCT was available; concerning generalisability the relation between endemic SM versus imported SM was investigated, with regards to IMP-Safety, the suggestion is to use artesunate when available. GMP artesunate will be available soon or later, even though administrative procedures for a specific license have to be followed (e.g. France)

JC proposes a multicenter and multinational trial in Europe (Equamat), but first of all he would like to understand if such a trial might be justified, and if centers will be willing to participate, taken for granted that funding is possible and the ethics committees give a positive approval.

Artesunate in Europe (By Peter J de Vries)

Quinine was introduced in the Netherlands more than 100 years ago. At the end of the 80s a project on Artemisia was performed, and this lead to the use of artemisine in the country, and later to the registration of artemotil. In the 90s a "private import" of artesunate to the Netherlands began. Since this was having very good results on patients, the ACE Pharmaceuticals began to import artesunate, through a special exemption to the Dutch Health Inspection. ACE imported Guilin products traded as Malacef with all certifications, licenses and testing facilities. Guilin artesunate is now not yet a GMP, however it has received a WHO pre-qualification. Import is now legalized as well as export to other European countries, though there are some limitations due to the fact that legal issues are different in each country: for example in Belgium there is an institutional import from the Netherlands, while in France import is centralized and it needs a temporary permission and obligation for pharmacovigilance is required (therefore it cannot be considered a "study"). In Germany some hospital pharmacies can buy artesunate from ACE. There has been a route through IP, but since ACE has the obligation to be able to trace usage, this route has been stopped.

PV asks if EMA registration is a better route to make artesunate available to all the European patients, though EMA poses an argumentation regarding the fact that a comparative trial is needed. In the opinion of PV the opportunity to conduct a comparative trial is not possible, first of all for ethical reasons. His proposal is, therefore, to participate in a pharmacovigilance programme, though this is also temporary, since Sigma Tau is developing a GMP product too. Pharmacovigilance is already active in Belgium and in the Netherlands, through a retrospective vigilance which allow to trace hospitals and prescribing doctors. France is also obliged to collect data, but it has to do it for ACE.

In the Netherlands ACE provided funds for a PhD students to study the issue. The conclusion that may be drown by this work confirm earlier findings, that means that artesunate is safe, active, and it clears parasite in 2 days.

There are different opinions concerning the fact that artesunate may be better than quinine. Some argue that artesunate is fast, of good quality (in many countries quinine cannot be bought, just Quinimax can be bought, but this has other alkaloids), it does not need a close monitoring, as on the contrary for quinine, it reduces the time to be in the intensive care unit, and therefore the time of hospitalization, and it requires less blood transfusions. However, other argue that there are not yet clear evidence that artesunate is better than quinine.

The StaphTrav project (by Philipp Zanger)

The StaphTrav project wants to be a network for the surveillance of imported *Straphylococcus aureus*. This disease recently spread due to migration, movements, importation.

Tübingen conducted a pilot study on this topic, which revealed that most of the genotypes are unknown in Europe, and therefore they come from outside Europe. On this basis Tübingen would like to study the importation of the *Straphylococcus aureus* into Europe through intercontinental travel, in order to promote public health by providing data on the importation on such strains and to define risk groups for targeted interventions.

Patients participating in the study (the first phase should last 12-24 months) must be permanent resident in an European country, must have pus producing skin infection on day of clinic visit and the onset of skin infection while abroad or within 30 days after return to home country from a trip outside Europe. A pseudonymised submission of patients data is foreseen. Centers taking part to the study have to be located in the country of the patient's residence and are asked to: (1) collect nasal or lesional swabs, (2) answer to a short questionnaire, (3) send the swabs and the questionnaires to Tübingen. Submitted centers will receive: *Straphylococcus aureus* culture results, the results of methicilin resistance testing, a summary report of the submitted strains genotyping including own and other centers. An annual report with be send to ETN too.

This study is for research use only and will have ethical approval in April 2011. Participating centers should obtain an ethical local clearance too.

The study center covers infrastructures and lab investigations, while the participating centers will have to cover ethical clearance, swabs, and postage (details have to be defined).

Additional information on the project may be found on www.staphtrav.eu or may be asked to info@staphtrav.eu