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

EUROTRAVNET SCIENCE WATCH : FEBRUARY 2010

Scientific Advances – Imported Methicillin-Resistant *Staphylococcus aureus*, Sweden. Stenhem M, Örtqvist A, Ringberg H, Larsson L, Olsson-Liljequist B, Hæggman S, Kalin M, and Ekdahl K. Emerg Infect Dis. 2010; 16: 189-196

Scientific Advances – Prevalence, clinical staging and risk for blood-borne transmission of Chagas disease among Latin American migrants in Geneva, Switzerland. Jackson Y, Gétaz L, Wolff H, Holst M, Mauris A, Tardin A, Sztajzel J, Besse V, Loutan L, Gaspoz JM, Jannin J, Albajar Vinas P, Luquetti A, Chappuis F. PLoS Negl Trop Dis. 2010 Feb 2;4(2):e592.

Scientific Advances – Review paper – Acute schistosomiasis, a diagnostic and therapeutic challenge S. Jaureguiberry, L. Paris and E. Caumes. Clin Microbiol Infect Dis. 2010; 16: 225-231

Scientific Advances – The practice of travel medicine in Europe. P. Schlagenhauf, F. Santos-O'Connor and P. Parola S. Clin Microbiol Infect Dis. 2010; 16: 203-208

Scientific Advances – Imported Methicillin-Resistant *Staphylococcus aureus*, Sweden.

Stenhem M, Örtqvist A, Ringberg H, Larsson L, Olsson-Liljequist B, Hæggman S, Kalin M, and Ekdahl K.

Emerg Infect Dis. 2010; 16: 189-196

Description: The authors analyzed 444 imported cases of MRSA acquisition reported in Sweden during 2000–2003. Risk for MRSA in returning travelers ranged from 0.1 (95% confidence interval [CI] 0.01–0.4) per 1 million travelers to Nordic countries to 59.4 (95% CI 44.5–79.3) per 1 million travelers to North Africa and the Middle East. Most imported cases (246, 55%) were healthcare acquired, but regions with the highest risk for MRSA in travelers showed a correlation with community acquisition ($r = 0.81$, $p = 0.001$). Characteristic differences in MRSA strains acquired were dependent on the region from which they originated and whether they were community or healthcare acquired.

ECDC comment: 2010-03-01
Countries such as Sweden that have a low prevalence of methicillin-resistant *Staphylococcus aureus* (MRSA) offer the opportunity to discern and study transmission of imported cases of MRSA. Knowledge of differences in transmission of MRSA may improve control measures against imported cases.

Link to the paper:

http://www.cdc.gov/eid/content/16/2/pdfs/189.pdf

Keywords : **Methicillin-restance - Staphylococcus aureus - Sweden**

This paper has been selected by Dr Philippe GAUTRET (philippe.gautret@club-internet.fr) from Marseille, France.

Scientific Advances – Jackson Y, Gétaz L, Wolff H, Holst M, Mauris A, Tardin A, Sztajzel J, Besse V, Loutan L, Gaspoz JM, Jannin J, Albajar Vinas P, Luquetti A, Chappuis F.

Prevalence, clinical staging and risk for blood-borne transmission of Chagas disease among Latin American migrants in Geneva, Switzerland.

PLoS Neglected Trop Dis 2010; 4(2): e592.

Description: 1012 Latin American undocumented migrants, including 485 Bolivians, were screened for Chagas disease at a primary health care unit of the Geneva University Hospitals, Switzerland. Chagas disease was diagnosed in 130 patients (prevalence: 12.8%), including 127 Bolivians (prevalence: 26.2%). All patients were in the chronic phase, including 11.3% and 0.8% with cardiac or digestive complications, respectively. Only 20% of infected migrants had been tested previously for Chagas disease. 18.5% and 26%.2% considered donating blood and organs outside Latin America, respectively.

ECDC comment: 2010-02-01

chronic Chagas disease is common among Latin American migrants in Switzerland and elsewhere in Europe. Screening for Chagas disease in non-endemic countries is recommended for Latin American persons with increased chance of (1) infection (e.g. Bolivian origin), (2) severe illness (e.g. immunosuppressed individuals), (3) transmitting T. cruzi to others (e.g. pregnant women, blood and organ donors) and (4) cure with existing treatments (e.g. newborns and children). Medical students and physicians in Europe should be made aware of the emergence of this neglected tropical disease.

Link to the paper:

http://www.plosntds.org/article/info%3Adoi%2F10.1371%2Fjournal.pntd.0000592

Keywords : **Chages – migrants - screening**

This paper has been selected by Dr François CHAPPUIS (francois.chappuis@hcuge.ch) from Marseille, France.

Review paper – Acute schistosomiasis, a diagnostic and therapeutic challenge

S. Jaureguiberry, L. Paris and E. Caumes

Clin Microbiol Infect Dis. 2010; 16: 225-231

Description: In non-endemic countries, acute (invasive) schistosomiasis (AS) is typically seen in non-immune travellers, whereas chronic schistosomiasis is more frequently diagnosed in immigrants. Travellers with AS initially present with non-specific signs such as fever, cough, headache, and urticaria. Life-threatening cardiac and neurological complications may occur. The positive diagnosis of AS relies on seroconversion, which appears together with hypereosinophilia approximately 3 weeks after the onset of symptoms. When prescribed during AS, praziquantel usually does not prevent the chronic phase of the disease and is associated with exacerbation of signs and symptoms in approximately 50% of cases. According to the published literature, corticosteroids may be recommended alone or in association with praziquantel. When associated with corticosteroids, pharmacokinetic interactions may impair the efficacy of praziquantel. The authors suggest that corticosteroids should be restricted to use in patients with systemic complications of AS, whereas praziquantel should be initiated only when ova are detected in either stools or urine, depending on the culprit species

ECDC comment: 2010-02-01

According to the authors, the main signs and symptoms of AS are fever, cough, headaches and urticaria but these may vary according to the infecting shistosoma species. More than one third of infected patients may have no signs of AS and as a consequence, individuals exposed to contaminated water should be investigated for shistosomiasis even in the absence of symptoms.

Link to the paper:

http://www3.interscience.wiley.com/journal/118544741/home?CRETRY=1&SRETRY=0

Keywords : Acute schistosomiasis, eosinophilia, invasive schistosomiasis, Katayama fever, Katayama syndrome, praziquantel
This paper has been selected by Dr Philippe GAUTRET (philippe.gautret@club-internet.fr) from Marseille, France.

Review paper – The practice of travel medicine in Europe

P. Schlagenhauf, F. Santos-O'Connor and P. Parola S

Clin Microbiol Infect Dis. 2010; 16: 203-208

Description: Europe, because of its geographical location, strategic position on trade routes, and colonial past, has a long history of caring for travellers' health. Within Europe, there is great diversity in the practice of travel medicine. Some countries have travel medicine societies and provisions for a periodic distribution of recommendations, but many countries have no national pre-travel guidelines and follow international recommendations such as those provided by the WHO. Providers of travel medicine include tropical medicine specialists, general practice nurses and physicians, specialist 'travel clinics', occupational physicians, and pharmacists. One of the core functions of the European Centre for Disease Prevention and Control-funded network of travel and tropical medicine professionals, EuroTravNet, is to document the status quo of travel medicine in Europe. A three-pronged approach is used, with a real-time online questionnaire, a structured interview with experts in each country, and web searching.

ECDC comment: 2010-02-01

The authors show that within Europe, there is great diversity in the practice of travel medicine. Some countries have travel medicine societies, and provide for an efficient distribution of recommendations. However, many countries have no national pre-travel guidelines and follow international recommendations such as those provided by the WHO or the CDC. Providers of travel medicine include tropical medical specialists, general practice nurses and physicians, specialist 'travel clinics', occupational physicians, and pharmacists. There is currently a dearth of guidelines regarding the required qualification to practice travel medicine and regarding certification. Each country has a distinct provider type profile, and there is also variation in whether travel medicine (both pretravel and post-travel) is provided for in the private or public sector.

Link to the paper:

http://www3.interscience.wiley.com/journal/118544741/home?CRETRY=1&SRETRY=0

Keywords : Europe, recommendations, travel medicine

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