



Society News

Message from the President

Dear Fellow Member,

Since my last message in NewShare, the world and travel medicine have been slowly recovering from the events of 9/11. Now we are influenced by the tragedy taking place in the Middle East. Again, the travel industry has been seriously affected, the result of feelings of uncertainty, and concern about possible retaliations.

In the last four months of 2001 the World Tourism Organisation reported a decrease of about 24% in international arrivals in North America, the Middle East and South Asia. Since the beginning of 2002, travel is increasing again, and we are seeing more travelers coming to our clinics. This shows how volatile the travel industry is and how quickly countries depending on tourism revenues can be badly hit. The same applies to travel medicine doctors and nurses whose source of revenue depends on this kind of client.

Let me give you an update on the Society. First, the May 2003 New York conference: both the organizers, Brad Connor in particular, and the scientific committee chairs and co-chairs have been extremely active over the last few months. A very attractive program is being set up and should be finalized after being reviewed by the executive board mid-May in Florence. Organization-wise, things are moving fast and several initiatives have been taken to make this venue as successful as our last conference in Innsbruck. It will be very different from the Alpine beauty of Innsbruck, as it will be held in Times Square, at the very heart of this unique city. This conference will certainly be inspired by the spirit of New York, and its place as a city of departure and arrival on the American continent.

When the chairs and co-chairs of the scientific committee met in New York in early April, we visited Ellis Island. This is an island off the southern tip of Manhattan. It is at Ellis Island where about 19 million immigrants arrived in America and had medical examinations before being allowed into the country. Up to 5000 newcomers a day were screened. Also known then as the Island of Hope, the screening center closed in the 1950s. Ellis Island is now a museum, devoted to the history of immigration and its health-related aspects. It is a very impressive place to visit. For travel medicine professionals, it can be seen as marking the beginnings of health services monitoring large population movements, and the health-related problems inherent to human mobility. Immigrants were certainly not tourists, but they were bringing with them all the questions and issues of prevention and treatment related to mobility.

A week after visiting Ellis Island, I had the opportunity to visit Riyadh, Saudi Arabia, and participate in the first conference on travel medicine ever organised there. In this very different environment, health professionals are also facing the impact of human mobility. Affluent Saudi travelers visit Europe, North America and other parts of the world, and experience the standard health problems that we see in our travelers. Simultaneously, every year two million pilgrims visit Mecca for the Hajj pilgrimage. They come from all over the world, generating the most formidable mixing of germs, cultures and mentalities, all in a matter of a few days. How can the situation be controlled? How should epidemics be prevented and care provided for those in need during the pilgrimage? Unique and very impressive expertise has been developed by Saudi doctors confronting these issues.

When we discussed travel medicine in Saudi Arabia, we also had to talk about migrants and foreign workers coming there and to the neighbouring Gulf States. Close to half of the 22 million resident population of Saudi Arabia comes from North Africa, Southeast or Southern Asia. Again, these are difficult health problems that must be handled in an efficient and adequate manner. This is a further demonstration that travel medicine cannot concentrate exclusively on tourists and affluent travelers if it is to tackle in a professional

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Certificate of Knowledge in Travel Medicine Examination Update

May, 2002

Question Writing Drive Underway: The question writing drive for the Certificate of Knowledge Examination is underway. The Examination Committee has received over 400 questions thus far. The goal is 500 questions. The Exam Committee will review all questions and 200 questions will be selected for use on the examination.

The Examination Committee Co-chairs, Drs. Phyllis Kozarsky, Jay Keystone, Robert Steffen, and Francesco Castelli would like to thank everyone who has participated in the question writing process.

Dr. Keystone acknowledged, "Without the talent, dedication and energy put forth by the question writers, this exam would not be possible. It takes a tremendous amount of time and thought to write good exam questions. We really value the contributions of this group."

First Examination Committee Meeting Set: The first face-to-face meeting of the Examination Committee will take place May 30- 31 in Atlanta. The group will come together to review the examination questions and discuss strategy.

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way contemporary realities of global mobility of populations and individuals. It is important to use a broader perspective, as lessons learned for one group of travelers can then be used for another group. In North America and Europe, for example, an increasing number - in some cases the majority - of imported cases of malaria are seen in foreign-born residents who have returned home to visit friends and relatives. The situation is the same for tuberculosis and hepatitis A seen in foreign-born residents. Therefore, even those diseases which most concern travel medicine are increasingly found amongst migrants, a high risk category of traveler.

Other members of the Society are working hard with Professor Lin Jianway to prepare the October 2002 conference in Shanghai. It will be the first conference on travel medicine held in China, organized by the Asia Pacific Travel Health Society, with the support of the ISTM. The program will cover broad issues in travel medicine, but will concentrate on the issues unique to this part of the world. This conference will well complement our biennial conference. Finally in May, the 3rd European Conference on Travel Medicine will be held in Florence, Italy, on the theme of « Travel and Epidemics ». These three major events illustrate that travel medicine is certainly very much alive, as is your society!

I am convinced that in order to grow and expand, the ISTM needs to consider and address the needs of all types of travelers: tourists and businessmen, students and expatriates, migrants and refugees. We have already included in the ISTM bylaws that the ISTM aims to promote "the protection of health of travelers and migrants...". Should we consider modifying the name of our society to the International Society of Travel and Migration Medicine? Please send comment to NewShare.

*Dr Louis Loutan
President of the ISTM*

Desert Survival

By Edward J. Otten, MD



Deserts comprise about 15 per cent of the earth's land area. An area is considered to be desert if it has less than 25 centimeters of rain, unevenly distributed throughout the year. Most deserts - Sahara, Arabian, Australian, and Kalahari (Southern Africa), for example - are found between 30 degrees South and 30 degrees North latitude, making them hot as well as dry. There are several large areas of "cold" desert, the Gobi, Great Basin, and Patagonian deserts, for example, which are found beyond 40 degrees North and South latitudes and have variable temperatures.

There are several climatic processes that produce desert areas. The most important of these are the six cells of air currents that descend at the poles and near the Tropic of Cancer and Tropic of Capricorn. These air currents, driven by the sun and the rotation of the earth, create areas of relatively warm, dry climate. The second important process is the problem of rain shadows caused by mountain ranges along the western edge of the continents. These areas lie to leeward of the prevailing winds and moist oceanic air is unable to rise over the mountains before it cools and loses its moisture on the western slopes. The dry air then rises over the mountain and descends to the land drying it. The Andes shadow the Patagonian Desert, the Sierra Nevada and Cascades shadow the Great Basin and Mojave in the U.S., and the Great Dividing Range in Australia places most of that continent in a rain shadow.

The dry land that is formed is unable to sustain a large amount of plant life. This lack of vegetation allows the sun's energy to directly heat the ground, allowing the heat to concentrate in the soil and in the air directly above it. In a forested region the plants give off moisture via transpiration. This along with the plants themselves absorb most of the sun's energy before it can heat the soil. The large surface area of the vegetation also disperses the heat energy so that the temperature on a forest floor rarely rises above 39 C (100 F). The combination of solar radiation, high winds and hot temperatures causes an increase in the evaporation of any moisture that does reach the desert.

The same factors that cause a high temperature during the day allow for a rapid loss of heat during the night. Temperatures may vary 25 degrees C in a single 24-hour period. It would seem that this climate would only allow for a sparse flora and fauna. This is not the case. Death Valley, where air temperatures have been recorded at 56 degrees C, has 600 species of plant, 30 species of mammal, 25 species of reptile, and 2 species of fish. The plants and animals that have evolved in this environment have developed ingenious methods for adapting to the aridity and extremes of temperature. Man, in order to survive in the desert, must adopt some of the same methods used by the indigenous organisms.

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Preparation for a Desert Climate

Obviously the more prepared you are for a particular climate the more likely you will survive, all other things being equal. Things are never equal however, and luck is probably the most important, albeit, the most uncontrollable factor. There are several controllable factors namely physical conditioning, clothing, survival kit, and survival skills that may prevent needless deaths in the desert.

Physical conditioning and acclimatization is probably just as important with desert travel as it is with mountaineering. The body's need for water cannot be lessened by these methods but the amount of electrolytes lost and the efficiency of the sweating apparatus can be optimized. Strength in the lower extremities may help prevent minor injuries, an ankle fracture, for example. In the desert environment such injuries can be fatal if you are unable to get help or water. Prior to a trip to the desert for the unacclimatized individual, I recommend a level of fitness at least equivalent to an aerobic workout to 80% of maximum heart rate for 30 minutes, 4 times a week.

Upon arriving in the desert you should spend at least 3 days acclimatizing before starting out on any long hikes (more than 8 kilometers). This will allow for the increased intake of water which may be 9 to 15 liters per day, the adjustment to the lack of vegetation, increased solar radiation, and the large temperature variations. Most activity should take place between dawn and 10 AM and between 3 PM and dusk. Between 10 AM and 3 PM, the hottest time of the day, it is best to stay in the shade and sleep, read or handle domestic duties.

The most important conditioning is mental conditioning or “the will to survive”. Throughout the survival literature this is constantly cited as the one thing that brought survivors through their ordeal. Unfortunately this cannot be taught. Fortunately, however, the potential is in all of us but may only appear in extreme circumstances. Many medical personnel

develop a sense of “aequanimitas” dealing with emergencies on a daily basis. Jet pilots seem to have a similar trait. While the “will to survive” is not exactly the same as these it may arise in unlikely individuals, just like courage in a battle.

The clothing most suitable for the desert is similar to that worn in most wilderness areas only the type of material may be different. Polypropylene, wool, pile, and goretex are the choices of the mountaineer whose enemy is hypothermia. While hypothermia is a possibility on the desert, hyperthermia and dehydration are more likely. Ripstop cotton is ideal due to its evaporative ability, and long sleeve shirts and trousers made from this material are excellent for desert conditions. A light color should be chosen to help reflect solar radiation. A pile jacket or wool sweater is needed at night in many desert areas. Most novices traveling in the desert remark on how cold it is at night and how ill prepared they were for it.

A rule of thumb is “expose as little skin as possible.” The skin must be protected from heat, ultraviolet rays, blowing sand, insects, and water loss. A hat is an absolute necessity and should be broad brimmed or a kepi to protect the neck and face. A cravat or large handkerchief can be used as an emergency hat if the other is lost. It can also be used as a towel or soaked in water and placed between the head and the hat to act as a solar air conditioner. Sunscreen and chapstick should be used frequently to protect exposed skin. Sunglasses or goggles are needed to protect the eyes. Ultraviolet keratitis similar to snowblindness can occur espe-

cially at higher elevations. Corneal abrasions from blowing sand are quite common and preventable.

Leather gloves protect the hands from hot objects as well as cactus spines and thorns. Footwear can be leather or manmade materials and should be ankle high or higher. Low cut shoes will allow sand to enter and do not give adequate ankle support. Jungle boots with metal spike protection and running shoes may get extremely hot in the desert soil and are not a good choice for desert travel. Polypropylene or polypropylene and wool socks seem to decrease the amount of blistering and give adequate cushioning and insulation to the feet.

Survival Kit

The survival kit should have the necessary equipment and supplies to help you survive yet be small enough to be carried with you wherever you hike in the desert. The principle component should be water or the means of acquiring it. Unfortunately water weighs about a kilo per liter and this limits the amount that an individual can carry to about one days' supply. A solar still should be carried along with water purifying tablets or iodine. The best way out of a survival situation is to be rescued, therefore signaling equipment is essential. Survival kit items should be selected that have multiple uses and they must be of high quality. Do not spare expense in purchasing equipment that your life may depend on. The following list is an example of a basic kit that may be carried in a relatively small pack:

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Example of Kit Items:

Nylon canteen, 5 liters	Penlight	Canteen cup
Space blanket	Clear plastic sheet, 1.5 x 1.5 meters	Sunscreen
Plastic tubing, 1.5 meters	Signal mirror	Iodine crystals
Whistle	Plaster bandages	Sunglasses
Swiss Army knife	Parachute cord, 15 meters	Waterproof matchbox
Compass	Insect repellent	Hard candy
Safety pins	Needle/thread	

— “Desert Survival,” continued from page 3 —

When weight is not a consideration, for example, traveling in an automobile, for example, the following items should also be carried:

- Plastic water container, 5 liters/person
- Folding shovel
- Toilet paper
- First aid kit
- Nylon tarp
- Gloves
- Extra clothing
- Food
- CB radio

Necessity being the mother of invention, many items from vehicles can be used in an emergency; the rear view mirror can be used to signal, the hubcaps to collect water, batteries to start fires, oil to produce smudge for signaling.

The best survival kit is of no use if you do not have the skills to use it correctly. These skills must be learned and practiced regularly or they will be lost. Until you have actually built a solar still you cannot anticipate the problems encountered. An experienced person can produce a solar still in 15 minutes. An amateur will take 60 minutes and lose more sweat than the still will produce in a week. Direction finding, fire building, shelter construction and signaling are all necessary skills that must be learned before getting into a situation where your life may depend on them. It is too late to learn to swim after you have fallen out of the boat.

“The rules of threes”

Priorities in a survival situation is based on the “rule of threes”, you can live 3 minutes without oxygen, 3 hours without warmth, 3 days without water and 3 months without food. Assuming that there are no immediate medical problems or environmental hazards, i.e. fractured pelvis, landslide, flash flood, etc., the top priority in a desert survival situation will probably be water.

If there is a limited amount of water available, then food should not be eaten unless the food contains a large amount of

water. The metabolism of food and excretion of waste products requires unnecessary usage of water. Water obtained from lakes, streams, wells or springs should be considered contaminated and purified before drinking. Water may sometimes be found by digging at the outside bend of a dry riverbed or stream. Vomiting and diarrhea caused by contaminated water can be quickly fatal in the desert. Rainwater, dew and water obtained from solar or vegetable stills are relatively pure. Urine, seawater or brackish water should never be drunk in a survival situation. Liquid from radiators is contaminated by glycols and should never be drunk. Many plants such as barrel cactus and traveler’s tree and animals such as the desert tortoise contain water. Such water can be used in an emergency.

A solar still can be made by stretching a 1.5 x 1.5 meter piece of clear plastic over a hole dug in the ground into which vegetation, urine, or brackish water has been placed. The sun will cause water to evaporate and collect on the underside of the plastic and then drip back into a container at the bottom of the hole. A tube can be used to remove the water from the container without dismantling the still. The amount of water produced will depend on the amount of moisture in the hole; bone dry sand will not be very productive. Build the still at night to conserve water. Dew, rainwater and edible animals may also be collected in the still as a bonus.

Shelter

Shelter is essential if the effects of the sun during the midday are to be ameliorated. The temperature in the desert will vary both above and below the ground. The temperature at the ground surface will be the highest. It will decrease as one goes below the ground and rises above it. Therefore a shelter that protects from direct solar rays and has within it either a trench 30 x 45 centimeters deep or a platform 30 x 45 centimeters high will be cooler than one in which you must be in contact with the ground. A second roof suspended 30 x 45 centimeters above the first will trap a layer of air and decrease the

temperature within the shelter. Metal vehicles will be like ovens and it is better to sit on a seat cushion in the shade of an automobile or under the wing of an airplane than to be inside. Try to build the shelter in the shadow of a cactus, tree or large rock. Avoid dry stream beds (arroyo, wadi or dry wash) that may turn into a killer flood in a matter of minutes after a cloudburst kilometers away. Desert animals will seek out shelter during the day also and may venture into your shade. Reptiles may be venomous and mammals may carry diseases such as rabies or plague. Most of them can be scared off with a stick or rock.

Waiting for rescue or trying to find civilization

One of the earliest decisions that you will have to make is whether to wait for rescue or to attempt to find your way back to civilization. You need to look at all the factors that may decide your survival. What is the chance that you will be rescued? If you filed an itinerary or flight plan, if you have signaling equipment, a radio or emergency locator transmitter, water, shelter and food; then you probably should stay where you are.

Your chances for rescue will be much better if you are near an object such as an airplane or automobile that can be seen by search and rescue personnel. If you do decide to travel mark a large arrow on the ground in the direction of travel and leave a note stating your direction of travel and plans. Travel in the cool of the night to conserve water, although the footing may be more hazardous. Before traveling in the desert or anywhere, obtain an up-to-date topographic map of the area and learn how to use a compass. Memorize major physical and manmade features so that if you get lost without your map and compass, you will still be able to find a road, river or powerline that may lead to help. Direction can be approximated by using the shadow tip method or a watch during the day or the stars at night.

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Signaling can best be accomplished during the day using a mirror and reflecting the sun off the mirror towards the horizon in the direction of potential help. If an aircraft is spotted, do not shine the mirror directly on the aircraft but rather alternate flashing the mirror from the ground to the aircraft. A signal such as this can be seen at 9,000 meters. At night, a fire or penlight can also be seen at great distances if shone from a high point. A mirror cannot be used up but penlight batteries and firewood can, so wait until you hear the sound of an aircraft or rescuers before signaling by these methods.

Nature is neutral; it is neither for us or against us. The game of survival like all games of life is based on our control of nature to the extent that we need to survive. This includes the nature inside of us as well as outside of us. The first step in any survival situation is to gain control of ourselves, then to try to control those things outside ourselves such as climate and terrain.

Bibliography:

Adolph, EF, Physiology of Man in the Desert. New York, Hafner Press, 1969.

Craighead, FC and Craighead, JJ, How to Survive on Land and Sea, 4th ed. Annapolis, Md, Naval Institute Press, 1984.

MacMahon, JA, Deserts. New York, Alfred Knopf, 1985.

U.S. Air Force Publication AFM 64-3, Survival Training Edition, Headquarters Dept of the Air Force, Washington, DC, 1969.

U.S. Army Publication FM21 -76 Survival. Headquarters Dept of the Army, Washington, DC, 1986.

Wagner, FH, Wildlife of the Deserts, New York, Harry Abrams, 1984.

Mel is the immediate past president of the Wilderness Medical Society and the Director, Division of Toxicology and Professor of Emergency Medicine and Pediatrics, University of Cincinnati College of Medicine, Cincinnati, Ohio, USA

Melioidosis

David Dance, MB, CHB, FRCPath

Melioidosis is the name given to any infection caused by *Burkholderia* (formerly *Pseudomonas*) *pseudomallei*. The organism is closely related to *B. mallei* (the causative agent of glanders) and *B. cepacia*. It has a wide host range including mammals (especially sheep, goats and pigs), birds and occasionally reptiles.

Epidemiology

The bacterium is an environmental saprophyte found in mud and water (e.g. rice paddy). It is endemic in south and south east Asia (especially Thailand and Singapore) and northern Australia. It is occasionally reported elsewhere in the tropics and is probably greatly underdiagnosed. The disease is highly seasonal, some 80% of cases presenting during the rainy season. Infection is usually acquired through inoculation, occasionally aspiration or inhalation of contaminated water, and hence is associated with soil contact (e.g. rice farmers). The role of ingestion is unclear, and person-to-person spread is very rare. Iatrogenic infections have occasionally been reported. In endemic areas, exposure is widespread (80% children in northeast Thailand have antibodies by 4 years of age), but disease is rare, and usually opportunistic (approximately 75% of individuals with severe infections are immunocompromised, especially by diabetes mellitus, chronic renal failure, thalassaemia, steroids, alcoholism and liver disease). Disease is commonest in males aged 40-60 years. The incubation period is variable - it may be as short as 2-3 days, but the organism may remain latent for up to 30 years before infection becomes apparent, usually at times of intercurrent stress.

Pathogenesis

The likelihood of disease developing depends on a balance between the host immune system (in which cell-mediated immunity and, particularly, interferon-gamma production appears to play a key role), the inoculum and, presumably, the intrinsic virulence of the infecting strain. Important virulence factors include li-

popolysaccharide, an extracellular capsule, and numerous enzymes. There is some evidence that intracellular persistence contributes to the recalcitrant nature of the infection.

Clinical

Melioidosis has a broad spectrum of manifestations. Overall, 60% of cases are bacteremic. Most of them have a community-acquired sepsis syndrome with a high mortality, although some have a more sub-acute 'typhoidal' presentation. Half have an obvious primary focus, usually in the lungs, sometimes in skin or soft tissue. Metastatic abscesses are common in any site, especially the lung, liver, spleen, kidney, prostate, and skin or soft tissue. The remaining 40% have localized infections, again in any organ, but particularly the lung, liver and spleen in adults, and these sites plus the parotid in children. Chronic foci often become granulomatous.

Diagnosis

Consider melioidosis in anyone who has ever lived in endemic area who presents with sepsis and/or abscesses, especially if they are diabetic. However, most imported infections will present within a few weeks of travel to an endemic area. The organism is easy to culture from sterile sites (e.g. blood, pus, urine), but selective media increase the isolation rate from sputum, swabs etc. Identification of *B. pseudomallei* requires a degree of suspicion, since it is often thought initially to be a contaminant, although most commercial kits should identify it correctly. *B. pseudomallei* is also a containment level 3 pathogen (UK classification), so warn the laboratory if melioidosis is suspected. PCR and antigen detection systems are

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under development, but are not yet in widespread use. Numerous serological tests (e.g. indirect hemagglutination, ELISA, immunofluorescence) for both IgG and IgM antibodies are available, but these have poor specificity and sensitivity in endemic areas, although they may be more useful in visitors from non-endemic countries. The high background seropositivity rates in endemic areas may partly result from exposure to a recently described, avirulent environmental organism, *B. thailandensis*.

Management

Supportive treatment, including drainage of abscesses, is important. *B. pseudomallei* is intrinsically resistant to many antibiotics, including penicillin and aminoglycosides. Newer beta-lactams substantially reduce mortality rates, but their cost limits their use in endemic areas. There is a lifelong risk of relapse, which may be reduced (but not abolished) by long antibiotic courses. Antibiotic resistance may develop during treatment.

Antibiotic treatment can be divided into the acute phase of treatment (usually about two weeks) and the maintenance phase (to complete 20 weeks of total treatment). Various antibiotic regimens are available for both phases of treatment. Ceftazidime, imipenem or meropenem are currently the treatments of choice during the acute phase. Medications for the maintenance phase include appropriate doses of chloramphenicol, but co-amoxiclav is preferable for children and pregnant women. A recent study found 12 weeks of ciprofloxacin plus azithromycin to be associated with an unacceptably high relapse rate (22%).

References and Further Reading

1. Acta Tropica. Volume 74, issue 2-3, February 2000.
This whole issue is devoted to melioidosis and contains a number of reviews of the subject, as presented at an international meeting that took

"Melioidosis," continued from page 5

place in 1998. Proceedings of a follow-up meeting in September 2001 should be published in due course.

2. Dance DAB. Melioidosis and glanders. In: Topley and Wilson's Microbiology and Microbial Infections. Ninth edition. Volume 3. Bacterial Infections. Hausler WJ Jr. and Sussman M, eds. Arnold, London, 1998. Chapter 46, pp. 919-29.

This is a fairly comprehensive, extensively referenced review of the subject up to 1996, when it was written, and is a good starting point for further reading. Some more recent key references are given below.

3. Bart J. Currie et al. Endemic Melioidosis in Tropical Northern Australia: A 10 Year Prospective Study and Review of the Literature. Clin Infect Dis 2000; 31: 981-6.

An excellent and comprehensive review of the disease from an Australian perspective

4. Simpson AJH et al. Comparison of imipenem and ceftazidime as therapy for severe melioidosis. Clin Infect Dis 1999; 29: 381-7.
5. Chetchotisakd P et al. Randomized, double-blind, controlled study of cefoperazone-sulbactam plus cotrimoxazole versus ceftazidime plus cotrimoxazole for the treatment of severe melioidosis. Clin Infect Dis 2001; 33: 29-34.

The two most recent published studies of acute phase treatment.

6. Chaowagul W et al. A comparison of chloramphenicol; trimethoprim-sulfamethoxazole, and doxycycline with doxycycline alone as maintenance therapy for melioidosis. Clin Infect Dis 1999; 29: 375-80.
7. Chetchotisakd P et al. Maintenance therapy of melioidosis with ciprofloxacin plus azithromycin compared with cotrimoxazole plus doxycycline. Am J Trop Med Hyg 2001; 64:

24-27.

The two most recent published studies of maintenance treatment.

8. Suputtamongkol Y et al. Risk factors for melioidosis and bacteremic melioidosis. Clin Infect Dis 1999; 29: 408-13.

The only case-control study of risk factors for melioidosis

9. Woods DE et al. Current studies on the pathogenesis of melioidosis. Microb Infect 1999; 2: 157-62.

A good summary of current work on virulence of *B. pseudomallei*, a rapidly developing field, using molecular techniques to study pathogenesis.

David is a physicians and a medical microbiologist and presently the Director of the Public Health Laboratory in Plymouth, UK. He has studied more than 1500 patients with melioidosis in Thailand.

Dear Editor:

The NewsShare newsletter of Mar/April 2002 has an excellent review article, Shark Attacks, by Dr. Paul Auerbach. But in view of ISTM's important role in immunization information, an error in this article is worth correcting. On page three, it says, "tetanus toxoid 0.5 mL IM and tetanus immune globulin must be given." I wouldn't quibble what with all the shortages now about using diphtheria tetanus, but the use of tetanus immune globulin is necessary only in those individuals who have not had a series of tetanus toxoid injections. It is a rare patient in the US that has not had this immunization.

Keep up the excellent articles and news.

John A. Knowles, MD

Calendar: Travel Medicine Conferences, Courses, Educational Travel

Conferences

March
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

Third Scandinavian Forum for Travel Medicine.

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

May
22-24

McGill Tropical Diseases Course.

Montreal, Canada. May 22-24, 2002. A review of clinical and laboratory tropical medicine. Sponsor: McGill University Centre for Tropical Diseases. Objectives: to assist clinicians, nurses and laboratory personnel dealing with tourists, overseas employees, immigrants, refugees and missionaries. Problem oriented. Includes hands-on clinical laboratory sessions.

Lecture material in English while lab instruction will be in English and French. Location: Concordia University amphitheatre in downtown Montreal. Contact: Kelly Ann McCulloch-Glover, Coordinator, McGill University Health Centre Continuing Education Office, The Montreal General Hospital, 1650 Avenue Cedar, Montreal, Quebec, H3G 1A4. Tel: (514) 937-6011 ext.44173 Fax: (514) 934-1779. E-mail: kelly.glover@muhc.mcgill.ca.

June
21-22

Travel Health Care Training Course for Registered Nurses, Nurse Practitioners, and Physicians.

Briarcliff Manor, Westchester County, NY (adjacent to New York City). June 21-22, 2002. Presented by travel Well of Westchester. Small group (maximum 20). 2-day course. Introduction to pre-travel health care and update, and review in a unique and friendly educational format. 16 CEUs applied for. Email: nurses@travelhealthnursing.com Tel: 914 793-9283

July
10

Third Annual Study Day in Travel Health.

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

Sep
8-12

Third European Congress on Tropical Medicine and International Health.

Lisbon, Portugal September 8-12, 2002. "Tropical Medicine: A Global Challenge." Under the auspices of the Federation of the European Societies for Tropical Medicine and International Health. Hosted by

the Instituto de Higiene e Medicina Tropical. his 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 Higiene e Medicina Tropical, Rua da Junqueira, 96 PT-1600 Lisbon Tel: ++351-21-365-2638 Fax: ++351-21-797-6242 Email: ip231874@ip.pt Web address: www.kit.de/tropical2002

Oct-
July

Diploma Course in Travel Health and Medicine.

London UK. Course taught each Monday, 1000-1600, from October 2002-July 2003. Provides post-graduate education and a qualification within the field of travel medicine to those actively involved or with a keen interest in the provision of travel advice. Open to both registered medical practitioners qualified with MBBS and nurses qualified with RGN, and other health care professionals holding relevant qualifications. A Diploma in Travel Health and Medicine (Royal Free & University College London Medical School, University of London) will be issued to those that successfully complete the course. Contact: Ruth Hargreaves, Course Administrator (Dr Jane N Zuckerman, Course Director) Academic Centre For Travel Medicine and Vaccines Royal Free and University College London Medical School Rowland Hill Street London NW3 2PF United Kingdom Tel: (44) 020 7472 6114 Fax: (44) 020 7830 2268 Email: r.hargreaves@rfc.ucl.ac.uk

Oct
22-25

Fourth 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: Official language: English - with simultaneous

Calendar (continued)

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

NOV
10-17

SAILS 2002: Shipboard Assessment, Intervention and Life Support for Cruise Ship Medicine. November 10-17, 2002.

Aboard the ship GTS Millennium. Sails from Ft. Lauderdale, Florida. Sponsor: Voyager Medical Seminar and New Hampshire Chapter of the American College of Emergency Physicians. For physicians and nurses interested in promoting and enhancing the delivery of quality medical services on board cruise ships. Computer technology including syllabi on PALM OS handheld computer and CD-ROM. The conference brochure and registration forms are available at www.vms4csm.com. Contact: Robert E. Wheeler, MD, FACEP, Voyager Medical Seminars, 9 Corduroy Rd. Amherst, NH 03031-2724. Voice/Fax (603) 672-5775. e-mail: vms@compuserve.com

NOV
12-16

Vascular Symposium in Hawaii – The Fourth Pacific Vascular Symposium on Venous Disease: The Aggressive Approach.

November 12-16, 2002, Mauna Lani Bay Hotel & Bungalows, Kohala Coast, Big Island of Hawaii, USA. Forty international guest faculty. The program will be a "Venous Symphony," with five controversial themes: (1) Acute Venous Thromboembolism, (2) Air-Travel Related Venous Thromboembolism, (3) Chronic Venous Disease, (4) Diagnosis of CVD, and (5) Varicose Veins. Targeted to surgeons, radiologists, and others interested in venous disease. Contact: Straub Foundation, 1100 Ward Avenue, Suite 1045, Honolulu, Hawaii 96814-1617; Tel: 808-524-6755, Fax: 808-531-0123, Email: straubf@straub-foundation.org Website: www.straub-foundation.org

May
7-11

CISTM-New York Conference of the International Society of Travel Medicine. New York. May 7-11, 2003. Contact:

CISTM8 Conference Secretariat: Talley Management Group, Inc., 19 Mantua Rd. Mt. Royal, NJ 08061 USA. Tel: (856) 423-7222 Ext 218. Fax: (856) 423-3420. Web address: www.istm.org.

Courses/Educational Travel

Feb
2-14
Feb 23-
March
7

Tropical Medicine Expeditions to East Africa:

7th Expedition to Uganda, February 2-February 14, 2003 and 10th Expedition to Kenya, February 23-March 7, 2003. In collaboration with the University of Nairobi and Dr. Kay Schaefer (MD, PhD, MSc, DTM&H) Cologne, Germany. Official language, English. The expedition is designed for a limited number of physicians, public health experts and scientists. During the 2 week-expedition the participants will visit different hospitals and health projects in urban and rural areas. Includes individual bedside teaching, laboratory work, and lectures in epidemiology, clinical findings, diagnosis, treatment and control of important tropical infectious diseases. Also, updates on Travel Medicine and visit to the "Flying Doctors" headquarters in Nairobi. 50 contact hours. Accredited certificate given. Contact: Dr. Kay Schaefer, Tel/Fax: +49-221-3404905, E-Mail: contact@tropmedex.com Homepage: www.tropmedex.com

June
8-28

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

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

Jan
27 &
March
28

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

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

IMPORTANT DATES

Conference
Early Registration
Regular Registration
Abstract Submission
Hotel Reservation

May 7-11, 2003
December 2002
March 2003
January 2003
March 2003



— “Certificate of Knowledge in Travel
Medicine Examination Update,” —
continued from page 1

“We eagerly anticipate this meeting and look forward to welcoming everyone to Atlanta. We are pleased to have such a hard-working and skilled group of experts committed to establishing this exam as the first internationally recognized credential in the field of Travel Medicine,” stated Dr. Kozarsky.

“*The Certificate of Knowledge Examination will be administered at the Marriott Marquis hotel in New York on Wednesday, May 7, 2003.*”

The Marriott Marquis is also the site of the 8th CISTM is being held May 7-11, 2003.

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

Eligibility: We would remind everyone that the exam is open to all licensed travel medicine practitioners including nurses, physicians, pharmacists, and physician’s assistants. Both ISTM members and non-members are eligible to participate.

For additional information and updates, please visit the ISTM web site at www.istm.org or e-mail Lori Kalata, Examination Coordinator, at: lkalata@wi.r.com.

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P.O. BOX 871089
 STONE MOUNTAIN, GA 30087-0028 USA
 PHONE: 770-736-7060
 FAX: 770-736-6732
 EMAIL: ISTM@ISTM.ORG

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ISTM NewsShare
 108-48 70th Road
 Forest Hills, NY, USA 11375
Tel: 718-263-2072
Fax: 718-575-0290
E-mail: newsletter@istm.org

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