TAISTEAL

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NEWSLETTER

ed. A. Weidenhammer

The Travel Medicine Society of Ireland

wish all our members a very Happy Christmas
and a Prosperous New Year
We look forward to seeing you in 2020

AYA-WHAT? - TROUBLE BREWING FOR VISITORS TO THE AMAZON

I have heard that some travellers to South America take part in ritual ceremonies. What's this about?

Some visitors to the Amazonian region of South America (mainly Peru, but also Colombia, Ecuador and Brazil) participate in nocturnal Shamanic rituals involving the use of the psychoactive substance ayahuasca. I have counselled two ayahuasca tourists in the past three months alone. Both were middle-aged, one male and one female. They were travelling alone to Peru but were not planning to trek the Inca trail. Both travellers had heard about ayahuasca from friends and through social media. They intended to visit ayahuasca retreats in the Amazonian jungle but were unsure how far they would be from the nearest source of medical care in the event of an emergency.

What exactly is ayahuasca and is it illegal?

Ayahuasca is described as a purgative hallucinogenic decoction, prepared from the ayahuasca vine (Banisteriopsis caapi), and is consumed as a broth or brew in special ceremonies conducted by Shamanic healers (curanderos). It is currently not illegal to ingest ayahuasca but its use is completely unregulated. It contains monoamine oxidase inhibitor beta-carbolines which block the breakdown of the psychedelic compound dimethyltryptamine in the user's intestine.

What effects do users of ayahuasca experience?

Ayahuasca induces a state of altered consciousness which lasts for up to 8 hours. This is accompanied by colourful visual hallucinations, sharpened sensory perception, dampened hearing and heightened mental alertness. Users are expected to vomit and experience diarrhoea (so-called 'purge') and this has special spiritual significance for them, affording them deeper insight into themselves and the world around them. Ayahuasca tourists are motivated by a desire for self-realisation and may be trying to overcome personal addiction or emotional problems.

Preparation of ayahuasca broth (Source: https://commons.wikimedia.org/wiki/File:Ayahuasca_prep.JPG)

Has anybody died from taking ayahuasca?

The study by Irmgard Bauer collated media reports of incidents, some fatal, relating to the use of ayahuasca but post mortem verification was lacking in most cases and it is currently unclear if ayahuasca per se caused these deaths. Multiple high-profile deaths among ayahuasca tourists have been reported in the media, including the fatal stabbing, in apparent self-defence, of a 26-year-old British man by a Canadian man near the Peruvian city of Iquitos. There have also been published reports of sexual assaults perpetrated by native ayahuasca purveyors disguised as traditional healers.

What advice should I give my travellers to South America?

Advise your travellers that ayahuasca ingestion is an unregulated practice. Recommend that travellers do not respond to individual agents handing out business cards at airports or on the high street at these destinations. Travellers should be reminded that there is absolutely no medical evidence for some of the medicinal claims of ayahuasca, including its cancer-curing potential although there is growing interest in psychiatry in psychedelic medicine. Tourists who are taking selective serotonin reuptake inhibitors (SSRIs) should be strongly advised not to use ayahuasca because of the risk of the potentially fatal serotonin syndrome. If travellers insist on taking part in ayahuasca ceremonies they should be accompanied by somebody they trust. They should also enquire about the purity of the ayahuasca brew in case it is mixed with other substances.

Recommended reading:

Bauer IL. Ayahuasca: A risk for travellers? Travel Med Infect Dis. 2018; 21:74-76. doi: 10.1016/j.tmaid.2018.01.002. Epub 2018 Jan 31.
Flaherty GT, Maxemous KK, Nossier RE, Bui YG. The highs and lows of drug tourism: a travel medicine perspective. J Travel Med. 2017 Sep 1; 24(6). doi: 10.1093/jtm/tax068.

Prof. Gerard Flaherty

TEST YOUR KNOWLEDGE – MULTIPLE CHOICES QUESTIONS IN TRAVEL MEDICINE:

By Dr. Joseph Sim.

1. Melioidosis:

[A] Is an emerging zoonotic disease caused by a parasite found in contaminated soil and water.
[B] Can be fatal if untreated ; Overall mortality rate can be up to 40%.
[C] Modes of transmission include inhalation, direct contact, ingestion and rarely human-to-human routes.
[D] Recurrence can occur after a complete course of treatment usually from re-activation.

2. Cruise Holiday:

[A] Outbreaks of infections can be sustained on multiple voyages due to transmission among crew members or by persistent environmental contamination.
[B] Land-based vector borne diseases do not affect cruise passengers.
[C] Approximately 50% of the passengers availing of on-board medical facilities age 65yo or more.
[D] Unlike air-travel, there are usually no restrictions for pregnant travellers going on cruise holidays.

3. Envenomation:

[A] Venomous = Poisonous
[B] Most snake bite deaths occur in Australia where some of the most venomous snakes are found.
[C] Heat therapy (immersing the affected body parts in hot water) is an effective initial treatment for envenomation as heat inactivates the toxins from venomous animals.
[D] Jelly fish can still emit toxins and cause injuries when dead or broken apart.

4. Anaphylaxis:

[A] Is an acute potentially life threatening reaction frequently as a result of allergic response to an offending antigen but can be non-allergic in rare cases.
[B] Biphasic or late response can occur in up to 20% of cases where patients experience recurrence of symptoms several hours after the initial episode.
[C] Non-immunologic triggers for anaphylaxis include cold temperature, physical trauma and exercise.
[D] Vaccination related vaso-vagal episodes are as common as anaphylactic reactions to vaccines.

5. Where is this?

(a) An island with a land area of 52 sq miles and a population of less than 2000, it is a rocky speck in the Indian Ocean nicknamed Galapagos of the Indian Ocean.
(b) The annual breeding migration of up to 50millions red crabs from the forest to the coast during the wet season (Oct / Nov) is a spectacular event.
(c) Standard vaccinations eg Hepatitis A, Typhoid, Rabies are recommended for visitors and precautions are needed against dengue and chickungunya. Beware of Ciguatera fish poisoning.

Answers on page 14

Extension of early bird registration: if you have not registered yet, there is good news: the deadline for the early bird registration has been extended to 2nd February! For more information about the conference, please visit the NECTM8 website

TMSI CONSTITUTION

I have asked the members of the Executive Committee (E.C.) to consider some changes to the existing TMSI Constitution with a view to proposing changes for approval by the general membership at the next AGM in April 2020.

The changes would include defining a category of student membership. They would also attempt to reconcile a number of factors: the maximum continuous term of service permitted on the EC (four years), the fact that most existing EC members have served longer than this, a lack of members coming forward to join the EC at the last four AGMs and finally a desire to avoid losing too much institutional experience were a large a number of existing EC members to finish their term of office simultaneously.

If proposed changes are finalised by the EC in late January/early February, then members will be advised of the proposed changes during February/March, at least three weeks before the AGM. An option for postal voting will be available for any members unable to attend the AGM.

I encourage any members who are interested to consider joining the EC at the next AGM.

The existing Constitution of the Society can be viewed on our website: http://tmsi.ie/index.php/about-us/constitution

The current EC members are listed here: http://tmsi.ie/index.php/about-us/meet-the-executive-committee

Simon Collins,
President (April 2018 – April 2020).

Our guest speaker at our Masterclass on 16th November 2019 in Liffey Valley, Dr. Andrea Holmes with Prof. Gerard Flaherty (left) and Dr. Simon Collins (right). Dr Holmes gave a very interesting lecture on 'Practical advice on sexual assault for travellers'. She is a consultant in Infectious Diseases, Genitourinary Medicine and General Internal Medicine.
She is also a Forensic Medical Examiner and Clinical Director of the Galway Sexual Assault Treatment Unit.

AN UPDATE ON VACCINES AGAINST EBOLA VIRUS DISEASE (EVD)

The current, ongoing Ebola outbreak in the Democratic Republic of Congo (DRC) is notable for what has not happened: no large-scale deaths of local healthcare workers, no increase in cases beyond about 15% of what was seen in 2014/15 in West Africa and no significant spread of cases to neighbouring countries. The critical difference I think, on this occasion, is the availability of vaccines and their deployment to about 250,000 people so far. These vaccines seem likely to be at least partially licenced during 2020 for use in Europe and the U.S. in the highest-risk patient groups initially (nurses in high-risk tertiary care units, lab personnel handling high-risk samples, aid workers responding to Ebola outbreaks). As the licencing process gathers pace in Europe, there are likely to be media headlines. You might receive enquiries from patients. It is in that context that I have written this article, to provide some background on where we have come from and where things are likely to go.

Ebola vaccine 'v920' (Merck)	Ebola vaccine 'Ad26.ZEBOV/MVA-BN' (Johnson & Johnson)
	

In the field of vaccination against infectious disease, a very significant story during 2018/2019 has been the use of novel Ebola vaccines among large populations. In the past 15 months, around 250,000 people have been vaccinated with the v920 vaccine in the east of the Democratic Republic of Congo. The current Ebola outbreak there is the second largest in history, yet is only about 15% of the size of the 2014/15 outbreak in West Africa. At the time of writing (mid-December 2019) the outbreak continues at a level of around 10 - 30 new cases per week, having peaked at around 120 cases per week in April 2019. When the current outbreak finishes and is analysed by epidemiologists, I suspect that the availability of an effective vaccine early in the outbreak will come to be seen as having been the key factor in relative containment of the current outbreak in comparison to 2014/15 one.

Current vaccines being used in eastern DRC:

Vaccine names:	Manufacturer:	Description:	No. of doses given to a patient:	Duration of immunity:
'rVSV-ZEBOV-GP' or 'v920' or 'Ervebo' or 'the Merck (Ebola) vaccine'	Merck (U.S.)	Live attenuated Vesicular Stomatitis Virus with Ebola protein	1 dose	2 years at least
'Ad26.ZEBOV/MVA-BN' or 'the Johnson & Johnson (Ebola) vaccine'	Janssen, a subsidiary of Johnson & Johnson (U.S.)	Being introduced as of November 2019	2 doses (day 0 & day 56)	2 years at least.

Some context on Ebola Virus Disease (EVD) risk:

In practical terms, the Ebola risk to the average traveller to Africa, as opposed to a local resident in an outbreak area, is virtually nil. This seems surprising, given the 30,000 cases from 2014/15 and over 3,000 cases in DRC now. To appreciate how difficult it actually is for a tourist, let alone an aid worker to acquire Ebola (and remember, almost all the aid workers in eastern DRC have not acquired it), it's necessary to understand a few key points:

- The virus is not airborne
- An infected person does not become symptomatic until 2 – 21 days after acquiring the virus
- Asymptomatic infected individuals are unable to transmit the virus
- Once an infected person becomes symptomatic (typically 4 – 8 days after acquiring the virus), they are invariably obviously unwell (pronounced flu-like symptoms of sudden onset). Their infectivity rises slowly at first, gathering pace over several days.
- Peak infectivity occurs in those who are severely unwell, pregnant women in labour and infectivity is at its most extreme in the bodies of those who have died i.e. infectivity rises exponentially with the passage of time during the course of the illness but is low in the initial couple of symptomatic days
- Within Ebola Treatment Centres in Africa, a separation distance of just 2 metres is considered sufficient to prevent transmission from the most infective cases to healthcare staff
- The vast majority of new cases occur in those who have handled significantly unwell Ebola cases without the use of gloves and gowns (relatives and, prior to the introduction of the new vaccines, frontline healthcare workers during the 2014/15 outbreak).

Understanding the above points explains why the secondary cases seen in the U.S. and Europe in 2014/15 were in nurses providing hands-on care to highly-infectious, critically ill patients who had been evacuated from West Africa. By contrast, an aid agency doctor who became unwell with Ebola in New York City following return from West Africa had taken the subway and gone bowling prior to feeling unwell and self-quarantining. Nobody else, including his girlfriend, became infected.

This in turn means that if the average traveller on a holiday to Uganda and planning to visit, for example, the gorillas in Bwindi Impenetrable Forest, just across the border from the current outbreak in DRC asks you if they might catch Ebola, the answer is "no; if you actually set out to try and contract Ebola, you would have to find a case, ensure that case was significantly symptomatic and then start handing and ideally, caring for that case".

Having said all that, Ebola has an amazingly high mortality rate (66% currently in DRC), those at highest risk need to be protected (contacts of cases, frontline healthcare workers, lab staff) and if a safe vaccine is available, it will eventually be offered to anyone who wishes to have it.

The background to the Merck ('v920') vaccine:

A direct historical line can be traced from the September 2001 terror attacks in the United States and the vaccine in use in DRC today. One week after the 9/11 attacks, anthrax spores were sent by surface mail to a number of U.S. politicians. This event and the preceding terror attacks led to a large funding increase by the U.S. government to agencies conducting research on vaccines against bioweapons. In the case of Ebola, the breakthrough with Ebola occurred not in the U.S. but across the border in Canada, where the researchers at the government's Public Health Laboratory (PHL) in Winnipeg, Manitoba succeeded in designing the vaccine in 2005. Tests on non-human primates showed a very high protective effect. The PHL is not mandated or equipped to conduct trials in humans and so looked for a private-sector commercial partner to take on the task of phase I (30 – 50 test subjects), phase II (300 – 500 test subjects) and phase III (3,000 – 5,000 test subjects) trials.

At the time, Ebola was a disease of little interest. Outbreaks had occurred since 1976 at least but had always been restricted to tens of victims and each event had terminated without spreading regionally. As a result, the PHL failed to find a willing buyer for the vaccine. In 2010, a PHL employee moved to the private sector, joining the U.S. company *NewLink Genetics*, a relatively small biotechnology company based in Iowa. The employee convinced his new employers that the v920 vaccine had important potential. NewLink bought the licence for the vaccine from the PHL for $205,000. Preoccupied with other projects, NewLink managed only limited human trial work with the vaccine.

The Ebola outbreak in West Africa in 2014 changed everything. Beginning in April, by the time the outbreak began receiving significant media attention in September, there was a sense that not only was it out of control regionally but that it posed international risks. On 30th September the first case in the U.S. was diagnosed in Texas. On 11th and 14th October the disease was diagnosed in two nurses who had cared for the initial case. By 16th October 2014 Congressional hearings were being held in public with the heads of the C.D.C. and National Institutes of Health being asked what, if any, additional funding they required and whether a vaccine was available. Simultaneously, the World Health Organisation (WHO) in Geneva was meeting, inviting vaccine manufacturers to offer any Ebola vaccine candidates they had under research for large-scale trials. WHO undertook to provide ethical and regulatory approval within hours or days, rather than the normal timeline of months and years. The large U.S. pharma company Merck approached NewLink and bought the v920 vaccine licence for $50 million.

At least 13 candidate vaccines against Ebola existed in late 2014. Three were trialled in West Africa in late 2014 and early 2015. The most important of the trial results[1] from West Africa related to the Merck vaccine. Investigators vaccinated about 3,000 people (group A), waited 21 days and then vaccinated another group of 3,000 (group B) who were matched by age and sex to group A. No Ebola cases occurred in group A. Sixteen cases occurred in group B. Statistical analysis suggested a 100% vaccine efficacy. A subsequent WHO expert group assessment revised this figure to 97.5%.

The use of the Merck vaccine in DRC:

The vaccine is now being used in DRC in two ways:

a) Vaccination of all front-line healthcare workers (staff at all primary care clinics and hospitals, ambulance drivers)
b) 'Ring' vaccination of Ebola cases identified in the community.

Picture: the concept of 'ring vaccination' – the index case is shown at the centre (credit: CDC).

The protective scope and effectiveness of the vaccine:

The Merck vaccine protects against only the Zaïre strain of Ebola, which has accounted for about 66% of all outbreaks since 1976, including the 2014/15 West Africa outbreak and the current eastern DRC outbreak. The other Ebola virus strains are shown in the map below.

Picture: Ebola outbreaks since 1976 and the four strains of the virus implicated on each occasion. Note that the Zaire strain makes up the majority of outbreaks, including the 2015/14 West Africa one and the current eastern D.R.C. one (credit: CDC).

The Johnson & Johnson vaccine does not protect against the Bundibugyo strain but appears to protect against all the other strains.

Logistical issues with the v920 vaccine:

The v920 vaccine is currently supplied in multi-dose (20 patient) vials and must be stored at -600C and once brought to normal fridge temperature (+20C to +80C), must be used within 14 days. In eastern DRC currently, the vaccine is available at designated Ministry of Health vaccination centres or is administered by teams administering ring vaccination in response to cases identified in the community.

Limitations in knowledge about the vaccines:

Much work remains to be done in order to fully establish the safety profile of the vaccines currently in use. Many questions remain:

- How long do they protect for (a minimum two years but how much longer)?
- Will booster doses be needed and how long will those doses protect for?
- Can they be given to pregnant women and the immunosuppressed?
- From what age will the vaccines work reliably?
- Are there side-effects yet to be discovered (one trial in Geneva has shown a post-vaccination arthritis occurring in 20% of Caucasian vaccine recipients[2])?
- To what extent, if any, will the Merck vaccine provide cross-protection against the non-Zaïre strains of EVD?

Likely future steps with the vaccines:

The vaccines remain unlicensed and have a 'compassionate use' designation in DRC. The Johnson & Johnson vaccine, which arrived in DRC in the final days of October 2019, has been earmarked for mass population vaccination in eastern areas of the country where no active outbreak is occurring. The Merck vaccine, requiring one dose only, is being reserved as the main outbreak-response vaccine. The Merck vaccine is progressing through the authorisation process in both Europe and the U.S. The vaccine gained 'conditional marketing authorisation' from the European Commission on 11th November 2019 and has 'priority review' status with the U.S. Food and Drug Administration, who are due to issue a decision on the vaccine in mid-March 2020. Manufacture of the Merck vaccine is likely to commence in Germany in the third quarter of 2020. While it may be some years before the vaccine is granted a full commercial licence, I can imagine that it would be available very soon in Europe with some conditions attached for use in individuals at highest risk (e.g. employees of Biosafety Level 4 labs who are handling Ebola samples for research purposes, nurses at a number of large hospitals in Europe that are designated to handle Viral Haemorrhagic Fever cases, aid workers being deployed to Ebola outbreaks and working hands-on with patients and contaminated materials).

The Johnson & Johnson vaccine is available in larger numbers currently but less research data is available on it. It may however turn out to be an even more valuable long-term prospect, given that it provides protection against more strains of EVD and with some indications that it may provide longer-term immunity.

A final philosophical reflection:

Ebola had been around since at least 1976 with regular outbreaks, yet it took the rapid spread of the disease in 2014, its appearance in richer countries and the consequent economic disruption that this threatened to focus political, regulatory and commercial minds in North America and Europe in a way that one seldom sees. It does show what can be achieved when an immediate, existential threat arises. One only wonders what it would take to focus the same minds on the production of effective vaccines against malaria, Dengue, a single-shot lifetime vaccine for influenza and many other diseases.

References:

1. Henao-Restrepo, Ana Maria, et al. "Efficacy and effectiveness of an rVSV-vectored vaccine in preventing Ebola virus disease: final results from the Guinea ring vaccination, open-label, cluster-randomised trial (Ebola Ça Suffit!)." The Lancet 389.10068 (2017): 505-518.

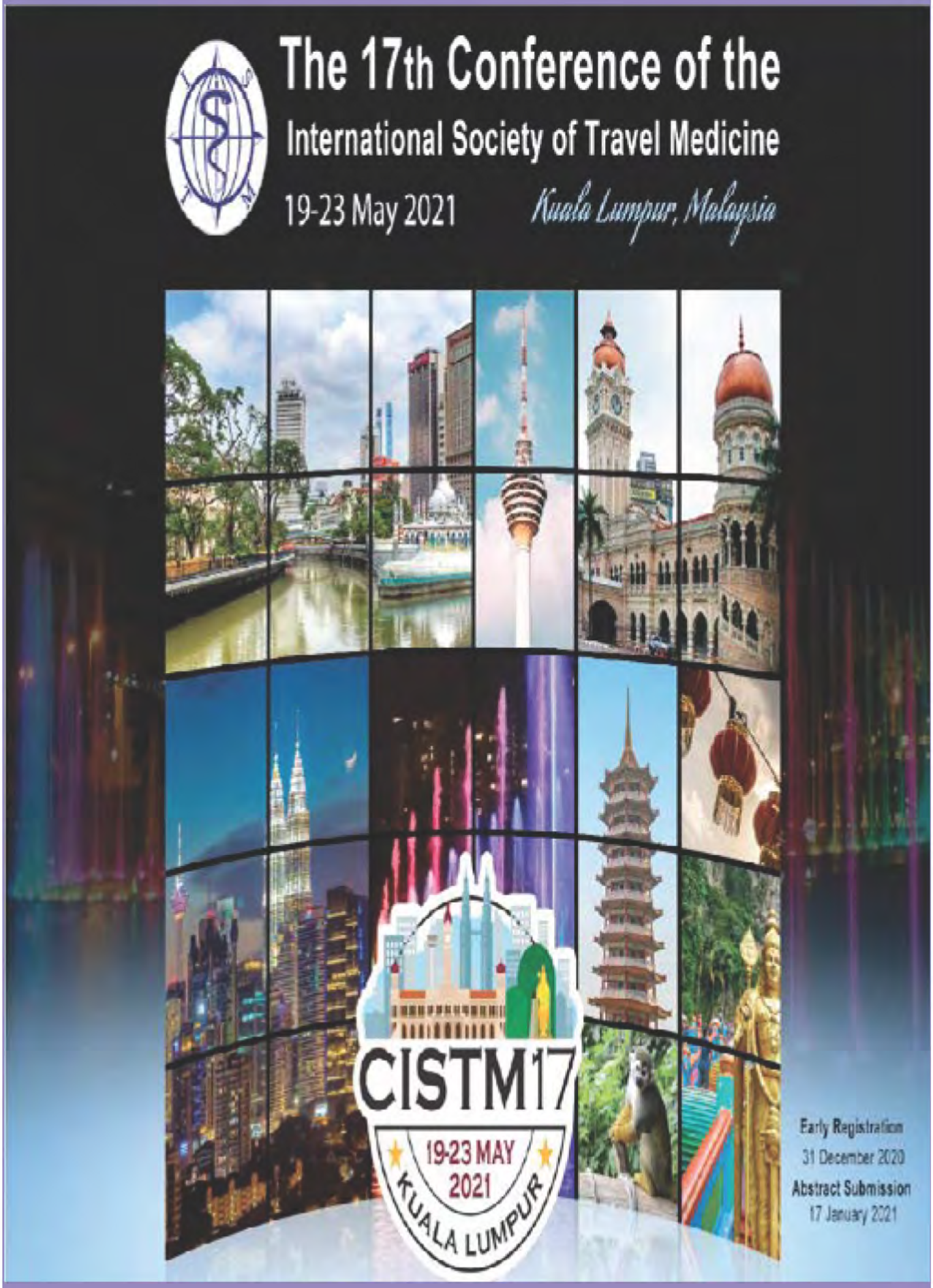
2. Huttner A, Dayer JA, Yerly S et al. The effect of dose on the safety and immunogenicity of the VSV Ebola candidate vaccine: a randomised double-blind, placebo-controlled phase 1/2 trial Lancet Infect Dis2015; 15;1156–66.

Resources:

World Health Organisation up-to-date situation report for D.R.C. http://who.maps.arcgis.com/apps/opsdashboard/index.html#/e70c3804f6044652bc37cce7d8fcef6c
U.S. Congressional hearings 16th October 2014: https://www.youtube.com/watch?v=FPAeGDciVGs
'Profits First: The Story of the Ebola Vaccine' Canadian Broadcasting Corporation (June 2018) https://www.youtube.com/watch?v=lnxmpoHADbs
C.D.C. Advisory Committee on Immunisation Practice (ACIP) meeting on Ebola vaccines 23rd October 2019: https://www.youtube.com/watch?v=I_YXeYxeAD4
'Ebola vaccine approved in Europe in landmark moment in fight against a deadly disease' 11th November 2019 https://www.statnews.com/2019/11/11/ebola-vaccine-approved-in-europe-in-landmark-moment-in-fight-against-a-deadly-disease/

Simon Collins.

The author worked in Ebola Treatment Centres in Sierra Leone in October 2014 and in Goma, DRC in October 2019 and was vaccinated with the Merck vaccine while in DRC. The views expressed in this article are his own.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MAYARO VIRUS (MAYV) – AN EMERGING THREAT FOR TRAVELLERS?

Mayaro virus is an arthropod-borne virus (arbovirus). A member of the Togaviridae family, genus Alphavirus, it has three known genotypes - genotype D is ubiquitous in Amazonia; genotype L is present only in Brazil; and genotype N is found in Peru. Transmission involves Culex mosquitoes (Fig. 1), esp. Haemagogus species but, experimentally, the virus may also be transmitted by Aedes aegypti and Aedes albopictus. In this regard, the worldwide expansion of vector Aedes albopictus is of some concern. Unlike Zika virus and Dengue virus, sexual transmission has not been described in Mayaro virus infection. Hosts include non-human primates, birds and reptile reservoirs.

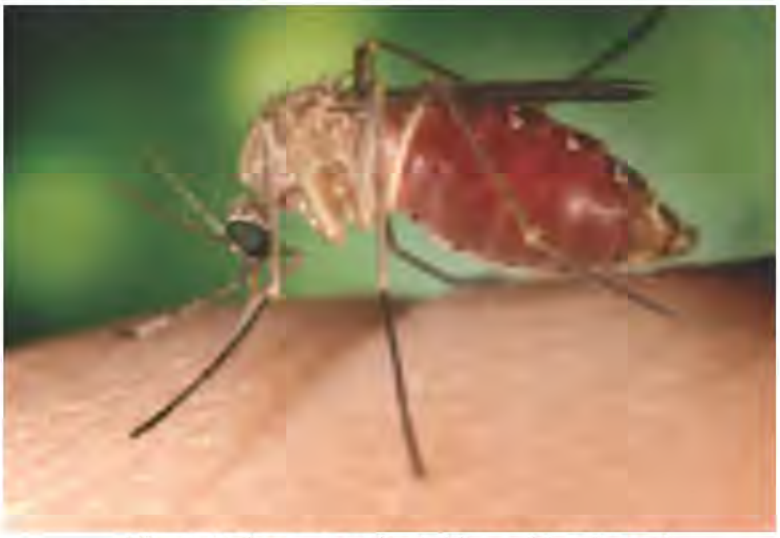

Fig. 1 Culex mosquito taking a blood meal

Mayaro virus was first isolated in Trinidad and Tobago in 1954 (Fig. 2). Four of the original cases were reported in male forest workers and indeed Mayaro virus seroprevalence in the population increases with proximity to a tropical rainforest. It has also been retrospectively identified in the sera of workers on the Panama Canal (1904-1914). Mayaro is similar to Chikungunya and Ross River viruses and is also likely to be under-diagnosed as it may be confused with Dengue virus infection. Small, occasional outbreaks have occurred in northern South America and Central America. There have been a small number of imported cases in Europe – e.g. in 2008 there was a case in the Netherlands which was imported from Surinam.

Fig. 2 Mayaro beach, Trinidad and Tobago

Mayaro virus infection causes mainly an inflammatory reaction during the acute phase with non-specific,

mild, self-limiting symptoms. Fever, arthralgia, myalgia, retro-orbital pain, and a maculopapular rash are frequently observed. Occasionally patients complain of nausea and vomiting, photophobia, abdominal pain, diarrhoea, cough, sore throat, and bleeding gums. Rare complications include myocarditis and haemorrhage. Only one lethal case has been reported in the literature, with haemorrhage, thrombocytopenia, jaundice and encephalopathy. Symptoms last 2-5 days. Fever can last 10 days and may reappear. Similar to patients with Chikungunya, Mayaro-infected patients can suffer a prolonged arthralgia which can persist for several months.

Treatment is symptomatic and analgesics and/or NSAIDs can be used. However, NSAIDs should only be used when Dengue virus infection has been excluded from the differential diagnosis owing to the risk of bleeding. There is no evidence for the efficacy of corticosteroids in management of Mayaro infection although chloroquine has been used for the resultant arthritis with some success.
Diagnosis relies on serology after 3 days of symptoms and RT-PCR. Anti-Mayaro IgM remain for up to 3 months while IgG antibodies persist for years. Serologic tests for Mayaro virus may cross-react with other alphaviruses. Prevention efforts include the use of insecticides at breeding sites, natural competitors and the isolation of viraemic individuals. As of November 2019, there is no licensed vaccine against MAYV. We are reading more and more reports of Mayaro infection in the literature so we should continue to watch this space closely.

Further Reading:

Hassing RJ, Leparc-Goffart I, Blank SN, Thevarayan S, Tolou H, van Doornum G, van Genderen PJ. Imported Mayaro virus infection in the Netherlands. J Infect. 2010 Oct;61(4):343-5. doi: 10.1016/j.jinf.2010.06.009.

Rodríguez-Morales AJ, Paniz-Mondolfi AE, Villamil-Gómez WE, Navarro JC. Mayaro, Oropouche and Venezuelan Equine Encephalitis viruses: Following in the footsteps of Zika? Travel Med Infect Dis. 2017 Jan - Feb;15:72-73. doi: 10.1016/j.tmaid.2016.11.001.

Sun J, Wu. Mayaro virus, a regional or global threat? Travel Med Infect Dis. 2019 Jul 25:101462. doi: 10.1016/j.tmaid. 2019.07.018

Prof. Gerard Flaherty

Congratulations to Ibinabo Gabriel Brown (2nd from left), a 4th year medical student at NUI Galway, on receiving the 2019 Irish Healthcare Award for Best Student Research Project. Gabriel's project investigated obesity and international travel and was supervised by Prof. Gerard Flaherty. The findings have been presented at the NECTM conference in Sweden and published in Journal of Travel Medicine. Gabriel completed the project in Croí/NIPC as a summer research scholar of the School of Medicine and was funded by a grant from the Travel Medicine Society of Ireland. Also pictured are Irene Gibson (Programme Lead) and Neil Johnson (CEO) of Croí.

NOTICE BOARD

Travel Medicine Society of Ireland Educational Bursary Scheme

Applications for this bursary are open to current members in good standing of the Travel Medicine Society of Ireland who have been members of the Society for at least 2 consecutive years. Applicants must be registered healthcare professionals resident and practising travel medicine in the Republic of Ireland. Bursaries will assist travel health clinicians who wish to attend a relevant educational event in Ireland or overseas (e.g. courses, conferences, seminars) by providing partial financial support to defray the costs of attending the event.

TMSI will reimburse successful applicants upon presentation of vouched receipts to a maximum amount of €500. Two such bursaries will be available for 2020.

Successful applicants are expected to disseminate information acquired to other members of TMSI by writing an article for the newsletter Taisteal and by presenting an OSKE on an agreed topic at two regional educational seminars. TMSI will publicise the outcome of the bursary scheme in its newsletter and on its website.

Members of the Executive Committee are not eligible to apply under this particular scheme.

For further details and application form please contact Anne Redmond at anne.redmond@tmsi.ie
Closing date for receipt of 2020 applications is: **31st January 2020.**

Dom Colbert Undergraduate prize in Travel Medicine

This will be the 5th year or the Dom Colbert prize in Travel medicine. The prize is open to all registered undergraduate medical students in the Republic of Ireland. This year's Essay title is " Climate Change: Implications for Travel Medicine". The closing date for entries by email to Anne Redmond is the 31st January 2020. The winning student will be announced in March 2020 and she/he will present their essay at the AGM seminar of the TMSI in April 2020

TEST YOUR KNOWLEDGE – ANSWERS FROM PAGE 3

Question	A	B	C	D
1. Melioidosis	False	True	True	True
2. Cruise True	True	False	True	False
3. Envenomation	False	False	True	True
4. Anaphylaxiss	True	True	True	False
5. Country:	Christmas Island			

Foundation and Diploma Courses in **Travel Medicine**

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
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Foundation Course in Travel Medicine

The Foundation Course in Travel Medicine is a **six month e-learning course** suitable for those working in the field of Travel Medicine.
The course includes:

- Introductory educational training session in Glasgow (*two days, attendance required)*
- Four e-learning units with assignments

Topics covered include:

Pre-travel risk assessment
Infections and epidemiology of infection
Immunisation theory, practice and available vaccines
Malaria

Diploma in Travel Medicine (DipTravMed)

The Diploma Course is suitable for healthcare practitioners working in the field of Travel Medicine. It is delivered through a blended e-learning approach over one full calendar year.

The course includes:

- An introductory residential week in Glasgow
- Module 1: ten e-learning units with assignments
- A mid-session residential week in Glasgow including an objective structured clinical examination (OSCE)
- Module 2: ten e-learning units of self study with practical exercises
- Module 3: a project chosen by the student
- A final written examination in Glasgow.
  Overseas students can opt to sit this examination in their own country by arrangement.

Student support (applicable to both courses):
All students are allocated a personal advisor and access to the course website, TRAVAX and e-Library. Online staff/student communication is also provided.

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For more information and applications, please contact:
Applications and administration: Lesley Haldane
+44 (0)141 241 6217 | lesley.haldane@rcpsg.ac.uk

Course content and curriculum: Ann McDonald or Clare Henderson
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www.rcpsg.ac.uk/travel-medicine

ROAD SAFETY TRAVEL RESEARCH

TMSI members will be aware that road traffic collisions are the leading cause of death in younger international travellers. Despite this, there are limited data in the medical literature on this important theme. Pre-travel consultations must address multiple elements and road safety can be easily overlooked. In collaboration with TMSI Executive Committee members and with Dr. Chris Sanford and Dr. Tara Simpson, based in Seattle, Washington, we have designed a simple survey to investigate travel medicine practitioners' usual practices in relation to the provision of road safety advice. The survey will be administered on two sites, one in the USA and the other among the TMSI members. The protocol for the study has been approved by an institutional review board. All responses are collected anonymously via a short online survey which will take 5-10 minutes for members to complete. As with all cross-sectional surveys, a high response rate (>50%) is necessary in order to draw reliable conclusions from the research. We hope to present our collective findings at an international travel medicine conference and to publish our work should it be of value to the practice of travel medicine. We appreciate how busy you all are but if you could take 5-10 minutes to complete our survey when it is emailed to you by Anne Redmond we would be very grateful. Anne will send a reminder email and the survey will remain open for 3 months to give members ample opportunity to give their responses. The link to the survey is: https://www.surveymonkey.com/r/6ZGM63R

Thank you very much.

Gerard Flaherty

LEPROSY IN SLIGO

Printed with the permission of Adrian O'Neill who runs the Sligo Heritage facebook page.
https://www.facebook.com/groups/605357269662532/1146197045578549/?comment_id=1149003795297874&reply_comment_id=1149024491962471&notif_id=1575829894619983&notif_t=group_comment_mention.

Leprosy wasn't unheard of in Ireland, those who had it were banished from towns in fear of catching it. And it's in areas of seclusion you'll find places that still bear the name to areas where hospitals were, that they were tended to.

There is a place in the parish of Cloonogill, in Bunnanadden called Flower hill, however this name has been completely changed to hide its true history.

The proper name is Cnoc á lobhair or in English, Hill of the Leper. Lobhair is Irish for leper and changed to the English word flower as it sounds similar and then the word Cnoc from Irish to English which is hill, therefore its present name Flower hill. We can assume that there was somewhat a hospital or area here that those afflicted with Leprosy were cared for.

Its also said that Beezies Island was home to those who suffered from Leprosy, and that the monks that resided at the church there took care of them long ago.

Below is an image of a 13year old with severe untreated leprosy taken from The Sick Rose: Disease and the Art of Medical Illustration book by Richard Barnett.

Sources: Woodmartin, History of Sligo, vol. 3. Pg. 64

NOTICE

If any of our members have unusual holiday photos which could be included on the gallery page, please send them in as a pdf

Photos can be sent to Anne at anne.redmond@tmsi.ie or to the newsletter editor at taisteal@tmsi.ie

SAFE THE DATES FOR UPCOMING MEETINGS:

1st February 2020: Travel Medicine Society of Ireland Meeting in the Midlands Park Hotel in Portlaoise. For further information please check www.tmsi.ie

4th April 2020: Travel Medicine Society of Ireland Annual General Meeting and Educational Meeting in the Talbot Hotel, Stillorgan, Dublin. For further information please check www.tmsi.ie

We are delighted to announce that our guest speaker at that meeting will be Professor Annelies Wilder-Smith, who is a world renowned expert in travel and tropical medicine, former President of the International Society of Travel Medicine (ISTM) and current Editor in chief of the Journal of Travel Medicine. Her special research interests include vaccine preventable and emerging infectious diseases, in particular related to arboviral diseases.

Items for the newsletter can be forwarded to:

taisteal@tmsi.ie

or

anne.redmond@tmsi.ie

Members Holiday Photo Gallery

Two heads are better than one. Peruvian Llamas - G. Flaherty

Sunset in Cyprus - S. Grehan

No need for winter coat. Bring on the sun-cream instead! Christmas in Perth. - J. Sim

Preparing for Ice-Lake Fishing to get X'Mas dinner; might as well make a cup of tea while we are at it. Deep in the forest in Norway. - J. Sim

Tarantula on a table in Cyprus - S. Grehan

Please pimp my car - a ;ess than roadworthy car in Havana, Cuba - G. Flaherty