NEWSLETTER

Travel Medicine Society of Ireland

TAISTEAL

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BACK TO BASICS
MALARIA PROPHYLAXIS

Introduction

Malaria prevention depends on mosquito bite minimisation allied with successful drug prophylaxis. The focus of this article is drug prophylaxis; achieving it involves getting a motivated patient on the right drug at the right time of day for the correct duration of prophylaxis. Two barriers to prophylaxis are patient resistance and uncertainty on the part of the prescriber. In this, the second of a series of 'Back to Basics' articles aimed at addressing the foundation practice of Travel Medicine, Simon Collins concentrates on strategies for achieving successful prophylaxis. The cornerstones of this are (a) patient handout aimed at addressing patient concerns and improving patient recall of the information imparted during the consultation and (b) malaria risk maps for the destination countries printed out and given to the patient.

Commonly used prophyaxis: Chloroquine (alone or in combination with Proguanil), Doxycycline, Atovaquone-Proguanil (Malarone™), Mefloquine (e.g. Lariam™).

Prescriber questions:

What can I use and when should it be used?

The easiest approach is to follow the recommendations in Travax (www.travax.nhs.uk), to which all TMSI members have access. Each country page lists prophylaxis recommendations in addition to a malaria risk map for the country, clearly showing the areas of the country for which prophylaxis should be used.

Will my choice of prophylaxis interact with other medicines or conditions?

A full list of cautions and interactions can be found in the British National Formulary[1] . A summarised list is presented here:

Medication:	Comments:
Chloroquine	Inhibited by cimetidine, interacts with digoxin, exacerbates myaesthenia gravis, inactivates the oral typhoid vaccine. Avoid in cases of psoriasis or epilepsy. Can be used during pregnancy.
Proguanil	Potentiates warfarin ('isolated reports'). Its absorption is reduced by magnesium trisilicate. Can be used during pregnancy.
Doxycycline	Effectiveness reduced by antacids, oral iron, phenytoin, cambamazepine, phenobarbitol, rifampicin. It potentiates warfarin, methotrexate, retinoids. Does not inactivate the contraceptive pill[2]. Avoid in pregnancy and children <12 years.
Atovaquone-Proguanil	Effectiveness reduced by tetracyclines (including doxycycline), rifampicin ('possible therapeutic failure of atovaquone'), metoclopramide, rifabutin. It potentiates zidovudine and weakens indinavir. Avoid in children <11kg. Normally not used in pregnancy.
Mefloquine	Avoid concomitant use with chloroquine, rifampicin, amiodarone. Potentiated by ketoconazole. Potentiates digoxin, beta blockers and calcium channel blockers. Avoid in cases of epilepsy, psycho-affective disorders, cardiac conduction defects, infants <5kg. Can be considered for use in pregnant women travelling to chloroquine-resistant areas[3].

Which patients do I need to be most concerned about?
Those travelling to Africa for the purpose of visiting friends and relatives ('VFRs'). Of Ireland's 82 recorded malaria cases in 2010, at least 64 (78%) were linked to Africa. 70% of Ireland's malaria cases that year were VFR cases [4]. It should be remembered that 82 cases in 2010 does not reflect the magnitude of the threat to travellers: malaria in Irish nationals that are diagnosed and treated abroad that do not appear in these figures.

Patient questions:
The most direct solution to addressing patient concerns is a handout, which (along with the Travax malaria maps of the countries which the patient plans to visit) can be printed off at the time of consultation. It can be tailored to your practice needs. It could address some or all of the following:

Chloroquine & Proguanil

Mefloquine (e.g. Lariam™)

Atovaquone-Proguanil (Malarone™)

Doxycycline

PATIENT CONCERN:	INFORMATION CONVEYED BY THE HANDOUT:
Why do I have to take these drugs:	Malaria is the most important infectious disease risk. It is responsible for more deaths than other infectious diseases. Prevention tablets work.
I have heard they don't really work?	96% of Ireland's malaria cases occur in patients who were either taking no prevention tablets or failed to complete the course[5].
I have heard you get side-effects with these tablets?	At least 80% of patients don't. Buy a one-week (three weeks in the case of mefloquine) supply initially and take them before the trip in order to see if you experience side-effects. Wait a week after your vaccines have been given before doing the trial. Buy the remainder of the tablets after the trial and before the trip.
I've heard you can get sunburn, nausea, heartburn or thrush with the tablets?	These side-effects can occur with Doxycycline but the risk is minimised by taking it with food in the morning (i.e. with breakfast). The use of a high protection factor sunscreen (e.g. SPF30) minimises sunburn risk.
When do I take them?	Before, during and after entering a malaria risk zone show on the printed (Travax) maps you have been given. ***Chloroquine:*** weekly, one week before, each week in a malaria risk area and for four weeks after. ***Proguanil:*** daily, one week before, each day in and for 28 days after. ***Doxycycline:*** daily, two days before, each day in a malaria risk area and for 28 days after. ***Atovaquone-Proguanil:*** one day before, each day in and for seven days after. ***Mefloquine:*** weekly, one week before, each week of risk and for four weeks after.
Are they expensive?	The approximate cost of a month's supply: Chloroquine: €9, Proguanil: €20, Doxycycline: €18, Atovaquone-Proguanil: €93 – €136 (shop around!), mefloquine: €20.
Are they cheaper if I buy them abroad?	Since one third of malaria prevention tablets in developing countries are fake, [6] it is a false economy to purchase them outside of OECD (EU, North America, Australia, New Zealand) countries.

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Finally, it is important that the patient information handout specifies that in the event of the patient developing a fever up a year after return from holiday (particularly in the first three months), they should alert the healthcare provider seeing them that they have visited a malarial area.

Conclusion.

Malaria prophylaxis works well if the patient is taking the correct prevention at the right time. Patient concerns to be addressed are the necessity for, side-effects of and cost of the medication. The use of handouts improves patient compliance and reduces the work of the prescriber.

Refrences:

[1]BNF 62 pp.415-419, 835, 842, 868, 883, 897

[2]BNF 61 p.496

[3]BNF 62 p.413

[4]Health Protection Surveillance Centre Annual Report 2010 http://www.hpsc.ie/hpsc/A-Z/Vectorborne/Malaria/EpidemiologicalData/

[5] Health Protection Surveillance Centre Annual Reports 2006-8 http://www.hpsc.ie/hpsc/A-Z/Vectorborne/Malaria/EpidemiologicalData/

[6] Nayyar et al, Lancet Infectious Diseases 2012 vol.12 issue 6 pp.488-496.

Dr. Simon Collins
MFTM RCPS (Glasg) MICGP DTM

NOTICE
The Annual General Meeting of the Travel Medicine Society of Ireland will take place on

Saturday 27th April 2013 in the O'Connell Suite of the Red Cow Moran Hotel, Naas Road, Dublin, at 9:15 am - 10:15am

following the AGM

Dr. Mike Jones Dean, Faculty of Travel Medicine, Royal College of Physicians & Surgeons, Glasgow will deliver the guest lecture entitled:

"Dilemmas in diagnosing and managing schistosomiasis in travellers"

Recognised for CPD
Bord Altranais approval

Items for the newsletter can be forwarded to:

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or
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MESSAGE FROM THE PRESIDENT

Dear TMSI Members,

I would like to take this opportunity to update you on recent developments within the Society and on some future plans for 2013. Last year was a busy year for the Society as we successfully hosted the Northern European Conference on Travel Medicine (NECTM) in June in Dublin, and the Faculty of Travel Medicine 'Nets and Bolts' workshop in November in Galway. This year the Conference of the International Society of Travel Medicine takes place May 20-23 in Maastricht. I hope to see as many TMSI members there as possible. It promises to be an excellent programme. Our Society continues to host its new format small-group teaching based regional seminars, with the first coming up on February 2 in Westport, followed by our AGM in Dublin on April 27. Dr. Mike Jones, Dean, Faculty of Travel Medicine, Royal College of Physicians & Surgeons, Glasgow has agreed to give the key-note lecture.

At our last Executive Committee meeting in Stillorgan it was decided to introduce a special Student membership rate of €15 as this will hopefully seed the Society with new members into the future. I will shortly be notifying the medical schools of this new category but already I have recruited 11 student members from our new special study module in Travel Medicine Research at NUI Galway. This is the first such module in Ireland and we are very excited about its potential. One of the tasks I have set the students is to each prepare a short summary of a recent research article from the travel medicine literature under my supervision. We publish these summaries in this issue in a new feature called "*What's in the papers*?". I will continue this feature in future issues of the newsletter. It is important that our Society is research active and this is a first step towards achieving this objective. I will keep you updated on the students' progress through this newsletter. I will also shortly announce details of two research bursaries of €500 each which our members can apply for if they have a good idea for a research study which they would like to get off the ground and publish in collaboration with TMSI.

The next issue will see a new feature entitled "Practical Travel Health Tips" in which our members contribute a short account of a trip they have taken as viewed from a travel health perspective. I will kick off with some practical advice gleaned from a recent trip to the beautiful country of Laos in South East Asia. The idea of this section is to give our members specific information from personal experience which cannot be found in the textbooks; this information can then be provided to our patients when they consult for pre-travel health advice.

In this issue also you will read a review of our very own Dom Colbert's latest book, "MCQs in Travel Medicine". This is a real gem and I would recommend it to all our members as a very interesting way to quickly learn a lot of travel medicine without having to consult a large tome. Congratulations on this publication, Dom!

In a fun new feature called "Where do you go to...?" we will invite our members to email us their answers to a series of questions about their travel experiences over the years. I will get the ball rolling by being the first interviewee! I can tell you I am not used to being interrogated with such soul searching questions, being normally a very private person! See what I have to say inside.

As always, we are very interested in hearing your views and suggestions. I want your membership of TMSI to be educational and stimulating and I want you to play an active role in the Society. Keep an eye on our website at www.tmsi.ie where you will see many new features in the coming weeks. Thank you to Conor Maguire and Anne Redmond and to all of you who have contributed to this issue of the TMSI newsletter, which has just been christened "Taisteal". Thank you also to our dedicated executive committee for their valued contributions to our regional seminars. I would like to take this opportunity to thank Dr. Peter Noone, Maria Callaghan and Patricia Brady for their support and hard work as executive committee members over the years and wish them well as they step down from the executive committee.

Dr. Gerard Flaherty
President, Travel Medicine Society of Ireland

WHERE DO YOU GO TO.....GERARD FLAHERTY, PRESIDENT OF TMSI?

When did you first catch the travel bug?

When I was a child, travel opportunities were more limited so I didn't fly overseas until I was 14, when I travelled to Boston to visit my brother and sister over there. I travelled alone so it was very exciting!

What do you most like about travel?

I find travel very relaxing. It gives me time to think and reflect. I am fascinated by other races and cultures and I love meeting the "natives" and learning from them.

How extensively have you travelled?

I have visited 60 countries so far, mostly in Europe and Asia, but I have also spent time in Latin America and Africa. I have a lot more exploring to do - it's a big world out there!

Which country did you most enjoy visiting?

This is a tough question. I enjoyed every trip, even if many of them were for work or study! I suppose a few countries stand out as being extra memorable and unique. Cuba was intriguing. I enjoyed trekking in Tanzania. South Africa is spectacular. My friend's sister had an apartment in Bermuda so we got to spend two wonderful vacations there playing golf without having to pay for accommodation. I visited China for the Beijing Olympics and I was really enchanted by the people and their culture. I'm currently learning Mandarin to prepare me for my next visit! I guess Japan was my favourite - it's so different. Within Europe I especially enjoy Italy and Iceland.

What was your favourite city to visit?

That's an easy one - Venice, without doubt. I've been there twice already. Such a beautiful city, pity it's so expensive. Jerusalem was also unforgettable. In Jerusalem I felt like I was at the centre of the world. It has a truly unique atmosphere. I hope to return there some day.

Are you an adventurous traveller?

I have done a lot of high altitude trekking overseas, so that's taken me to Kenya, Tanzania, Peru, Nepal, Russia, Borneo, Japan and Mongolia. I've also done whitewater rafting in Nepal which was great fun. I like to go off the beaten track, but I've become a much more cautious traveller over the years, as I learn more about travel-related health risks!
When I visit cities I like to see as much as I can on foot. I only got blisters once - from walking around Tokyo in sandals on a very hot day. I had great fun trying to navigate this huge city without more than a few words of Japanese. Japan is unique and the people were wonderfully polite. It wasn't easy climbing Mount Fuji the following night with blisters I can tell you!

Are there any aspects of travel which you don't enjoy?

I don't enjoy poorly organised and inefficient airports. Long bus journeys such as the one I took recently from Vientiane to Luang Prabang in Laos are also quite challenging. It's never nice when the hotel you've booked doesn't meet your expectations but I tend to be very forgiving of local facilities, especially in low-income countries.

What can travel teach us about ourselves?

Travel can make us so much more aware of the world we live in and its people. It has made me more tolerant and more patient and it has also made me appreciate how fortunate I am to be living and working in a stable, relatively safe and climatically moderate country like Ireland.

Can you give us one useful travel tip?

Respect the local people and their customs. Never get angry. Don't look lost. Never let your guard down. To avoid travellers' diarrhoea order a different dish to your partner, but then don't share your food. There are many others which I should put into a book chapter some day. I try to learn from my mistakes during previous trips.

Have you any interesting trips coming up?

I'm just back from a trip to Malaysia and Laos. I go to Malaysia frequently with our medical school as many of our students at NUI Galway are Malaysian. I'm hoping to visit Myanmar during another trip to Malaysia this year. It's nice to add on a few days at the end while I'm that far. I'm also going to Morocco with friends in June and a few of us are hoping to spend Christmas 2013 in Argintina, if funds allow!

INTERNATIONAL SOCIETY OF TRAVEL MEDICINE

BOOK REVIEW

MCQs in Travel Medicine. Author Dr. Dom Colbert. Published by Oxford University Press.

When Dr. Dom Colbert, Fellow of the Faculty of Travel Medicine at the Royal College of Physicians and Surgeons of Glasgow, speaks on travel and tropical medicine, people listen attentively. Not only is Dr. Colbert a gifted teacher with an innate ability to explain complex clinical material in a simple and memorable way. I should know - he taught me all the Clinical Physiology I know at the National University of Ireland, Galway! Not only do his audiences admire his encyclopaedic knowledge of travel and tropical medicine and the humble manner in which he generously imparts this knowledge. No, people listen to Dom because he speaks from personal experience. He is widely travelled, much of the travel to the tropics and in the service of others. It comes as no surprise then that the royalties from this book, his fifth, are being donated to AboutFace, a UK-based group of volunteer surgeons who correct facial deformities in poor people in India. Dom Colbert speaks and writes with considerable credibility on travel medicine because he has a wealth of practical clinical experience in the tropics. His contribution to healthcare in the most deprived parts of sub-Saharan Africa was recently recognised by the award of a Fellowship from the College of Surgeons of East, Central and Southern Africa.

'MCQs in Travel Medicine' is a humble title indeed for Dom's latest work. While many collections of MCQs are nothing more than a series of poorly constructed questions with little by way of explanation, this book is a truly valuable educational resource and one which will satisfy the learning needs of a diverse range of students, healthcare workers and researchers. At a time when curricula in global health are emerging in Irish and British medical schools, this book will also become an invaluable revision aid for medical and nursing students, especially those undertaking electives in developing countries. Every travel medicine practitioner, be they doctor, nurse or pharmacist, will learn something from this book. The author manages to cover a wide array of topics while helpfully repeating points of greatest clinical significance throughout the book. One of the fundamental tenets of medical education is the importance of establishing prior knowledge. By completing the MCQs the reader first gauges his baseline knowledge before reading the expanded answers and addressing any gaps in his understanding.

The format of questions is identical to that followed by the International Society of Travel Medicine in its Certificate of Travel Medicine examination which will be accepted as an entry pathway to the Glasgow Faculty of Travel Medicine Membership Part 2 examination. The book will be indispensable to candidates for the Glasgow Diploma in Travel Medicine, the Diploma courses in Tropical Medicine and Hygiene at the London and Liverpool Schools of Tropical Medicine, and the Diploma in Tropical Medicine offered by the Royal College of Surgeons in Ireland. Answers are expanded with sufficient explanation so that the reader understands but is stimulated to study the subject further. True to Dom's famed pedagogical style, the answers are elaborated in a very direct, conversational tone, which challenges the reader and provokes further enquiry and discussion.

In addition to the themes one would expect a travel medicine book to cover, there are welcome sections dealing with oft neglected topics, such as skin protection, special groups of travellers, adventure travellers and access to medical care overseas. Many important travel-related health risks such as travellers' diarrhoea, malaria and sexually transmitted infections are grouped together under the heading 'Specific medical risks for the traveller'. Dengue infection is given the attention it deserves and the author devotes a whole section to investigation of the returned ill traveller, emphasising the continuum of responsibility borne by the travel medicine practitioner, from pre-travel to post-travel. The book concludes with a challenging 25-question self assessment exercise and a very useful aide-memoire for those readers who occasionally confuse their leishmaniasis, trypanosomiasis and filariasis!

The author has given great personal service to travel medicine over many years, having founded the Irish Society of Travel Medicine, now the Travel Medicine Society of Ireland, at a time when travel medicine was only just being recognised as a discrete discipline. 'MCQs in Travel Medicine' is another example of this commitment to service and it should be on every travel medicine practitioner's desk. In addition it will prove useful for trainees and specialists in Infectious Diseases, Public Health Medicine, Occupational Health and Pharmacy. Aid workers on overseas missions with Non-governmental Aid Organisations will also find this book very interesting in helping them to understand their new tropical environment. Many books present information, but so few impart wisdom. This is one of those rare books.

Dr. Gerard Flaherty

NETS & BOLTS

Report on the Faculty of Travel Medicine Nets and Bolts Workshop hosted by the Travel Medicine Society of Ireland on Saturday, November 10 in Croí House, Galway, Ireland.
Convenor: Dr. Gerard Flaherty, FFTM RCPS (Glasg), President Travel Medicine Society of Ireland

Dr. Gerard Flaherty, T.M.S.I., Anne Redmond, T.M.S.I., Neil Johnson, CEO of Croí

TMSI are delighted to have hosted the first Nets and Bolts workshop held outside the United Kingdom. Croí House proved to be an excellent venue and the Croí team did a fine job in providing audiovisual support, arranging hotel accommodation for visiting speakers, looking after all the catering and engaging a professional photographer. We are indebted to Mr. Neil Johnson, CEO of Croí, for his enthusiastic support.

We managed to keep the registration fee low (€45 for TMSI and Faculty members,€60 for non-members) by negotiating financial support from SPMSD and GSK. This funding also covered the facility fee, catering, hotel accommodation, travel expenses for the presenters. No financial loss was incurred by hosting the workshop.

A total of 28 delegates (roughly 50% doctors and 50% nurses) registered to attend the workshop but two failed to turn up on the day. After an introduction from Dr. Gerard Flaherty, including promotion of the Faculty, Dr. Conor Maguire, MFTM RCPS (Glasg) delivered an interesting plenary lecture on the prevention of hepatitis in travellers. Delegates then rotated through four 30-minute workshop stations, punctuated halfway by a 15-minute coffee break. Most of the presenters were drawn from the Executive committee of the TMSI. Patricia Brady, an experienced travel health nurse, facilitated a session on the use of insect repellents. Distinguished travel medicine physician and author, Dr. Dom Colbert, FFTM RCPS (Glasg) demonstrated the use of mosquito bed nets. President-elect of the TMSI, Dr. John Gibbons, discussed options for malaria chemoprophylaxis, while Dr. Simon Collins, recently conferred with MFTM RCPS (Glasg), lead a discussion on screening of the returned traveller.

After a very satisfactory 3-course lunch, delegates received instruction on vaccine preparation and administration from Nurse Maria Callaghan. Dr. Tom Donnelly conducted a workshop on travel-related sexual health issues. Dr. Paul Hickey, a military GP, demonstrated the various techniques of water purification, while Dr. Gerard Flaherty entertained groups with a practical demonstration of the use of a portable hyperbaric chamber in the context of a discussion on high altitude illness management. Delegates received the following items in their registration pack: name badge, programme outline, learning objectives, recent copy of the Faculty newsletter Emporiatrics, application form for affiliate membership of the Faculty, and application form for TMSI membership.

Evaluation forms returned on the day reflected very positively on the workshop format, speaker quality, and facilities. TMSI wishes to express its gratitude to the Faculty of Travel Medicine for permission to host the Nets and Bolts workshop.

Dr. Gerard Flaherty

RABIES STILL A PROBLEM IN BALI

The CDC has issued a warning about the ongoing epidemic of Rabies in Bali. A full report will appear in the April issue of Emerging Infectious Diseases Journal. Rabies first appeared in Bali in 1884 but the present outbreak took hold in 2008. 130 people have died and more than 130,000 have received post exposure prophylaxis. The government has implemented a strong canine vaccination programme with the help of the Australian government. Mass vaccination of dogs consists of an initial vaccine and a booster at three months. So far an estimated 40% of dogs have received a first dose and 25%, the booster with the help of the World Society for the Protection of Animals. Culling of strays through poisoned bait is taking place alongside. Only two cats were confirmed with Rabies making it almost exclusively a dog problem. Four of the confirmed dogs were vaccine failures. Cold chain supply of vaccine is a problem in Bali.

Efforts to control the spread of Rabies are hampered by the easy access by sea from neighbouring Indonesian islands. It is thought that the present outbreak was caused by the landing of a dog on a fishing boat. Other factors favouring the spread include the large number of stray dogs, lack of dog registration as well poor case notification and limited resources. Culling is often haphazard. Vaccinated dogs and family pets have been included, leading to the movement of pets to avoid detection. This may have facilitated spread. The incidence of dog bites, while high, does not reflect the true prevalence of Rabies, because more bites were reported during the Bali campaign then were reported in neighbouring Indonesia where Rabies is endemic. Rabid dogs generally bite without provocation and die less than ten days after clinical signs develop.

Travellers to Bali and Indonesia need to be warned to avoid contact with dogs, both domestic and strays. Post exposure prophylaxis is still difficult to obtain. It is hoped that vaccination of dogs and culling of strays will return Bali to Rabies free status; however the problem in Indonesia remains. The WHO considers the risk of Rabies to travellers to be high and pre-exposure immunisation is recommended for travellers and other people for whom contact with domestic animals, particularly dogs is likely.

Reference:
Putra AAG, Hampson K, Girardi J, Hiby E, Knobel D, Mardiana IW, et al. Response to a rabies epidemic, Bali, Indonesia, 2008–2011.
Emerg Infect Dis [Internet]. 2013 Feb.
http://dx.doi.org/10.3201/eid1904.120380

Dr. Conor Maguire

Annual General Meeting

of the

Travel Medicine Society of Ireland

27th April 2013

in Red Cow Moran Hotel

Naas Road, Dublin

Guest Lecturer: Dr. Mike Jones

Lecture: "Dilemmas in diagnosing and managing schistosomiasis in travellers"

STUDENTS TRAVEL MEDICINE COURSE

Pictured at the TMB clinic in Eyre Square, Galway are, from left to right, Adam Byrne, medical student and group leader, Dr. Gerard Flaherty, course director, Joyce Keaveney, travel health nurse, and Andrew Lewis, CEO of Tropical Medical Bureau.

NUI Galway, in collaboration with the Tropical Medical Bureau (TMB), has recently delivered a novel course in travel medicine to its second year medical students. Designed by Dr. Gerard Flaherty, Senior Lecturer in Clinical Medicine and Medical Education at NUI Galway, the 10-week special study module introduces students to the medical preparation of a wide range of travellers, from backpackers and holiday-makers to aid workers and business travellers. Commenting on the collaboration, Dr. Graham Fry, Medical Director of TMB, said "Students gain valuable exposure to travel medicine practice at the TMB clinic in Galway. They spend time with the travel medicine physician during patient consultations and they learn how to prepare and administer travel vaccinations with the travel health nurse". In addition, students work closely with Dr. Flaherty in reviewing the travel medicine literature and have collaborated in designing an airport travel health survey, which they hope will lead to a published article. Reflecting on the initiative, Dr. Flaherty, current President of the Travel Medicine Society of Ireland, said "I am delighted that NUI Galway is one of the few institutions in the British Isles to give medical students the opportunity to learn about protecting the health of the travelling public. The partnership of NUI Galway with the TMB is a very welcome one and we are hopeful that it will lead to significant research output in travel medicine. The College of Medicine, Nursing and Health Sciences is also delighted to acknowledge the teaching contribution of Joyce Keaveney, travel health nurse with TMB, by awarding her Honorary Clinical Fellowship".

ARAK: A DRINK TO DIE FROM

Bali, the Gili Islands, Lombok

Three years ago, Rachel Craig, finished her university studies and decided to travel. Her vaccinations and travel health plans were taken care of at Our Lady of Lourdes Hospital, Drogheda, where her mother and I are work colleagues. On May 31st 2009, Theresa and Noel received the news which is every parent's worst nightmare: their daughter Rachel had died on the island of Gili Trawangen near Bali, Indonesia. Rachel was a victim of methanol poisoning in an outbreak which killed 25 people in a two week period.

Rachel had travelled widely all over Europe, Asia and South America. She had a passion for travelling and meeting new people. She was a wise and responsible traveller who avoided risks. It has taken until now for Rachel's parents to come forward and talk about the tragedy which struck their lives. Noel Craig, Rachel's dad had this to say: "Initially we thought this was a once off tragedy and local authorities did nothing to dispel that idea. However we now know that this is still continuing to happen."

Tourists to the Indonesian island of Bali have been warned against drinking the local spirit after 25 people died of alcohol poisoning in May 2009. Arrack is a potent alcoholic drink, popular in Indonesia, brewed from coconut, palm sap, rice or fruit and is a much cheaper alternative to imported spirits or beers. It is sometimes referred to as Arak but should not be confused with true Arak or "Araq", popular in Middle-Eastern countries which is an aniseed flavour spirit, similar to the French drink Pastis. The process of adding other substances to Arak in order to drastically increase its potency and reduce its cost has become frighteningly common in South East Asia. A bottle of vodka is equal to one month's wages in Bali. Arak might be brewed or adulterated locally as a cheaper alternative to imported alcohol which is heavily taxed. Local brewers might add Methanol to fortify the drink. Noel warns that "there is no discernible smell, taste or colour. This is not a case of naive tourists taking a risk for a cheap drink; the risk to life is real. There is no way of knowing if a drink is contaminated or not".

Drinking cheap alcohol in many areas is risky, particularly where medical assistance is limited as in Rachel's case. Follow up investigations by local authorities were ineffective. To this date Noel and Theresa have received no official report of the investigation into the Rachel's death. No criminal proceedings have taken place and nobody has been held responsible.

In April 2010, 22 people died by drinking contaminated alcohol. May 2010 saw the death of eight more victims of Arak poisoning and in June 2010, twenty three people died and 500 were severely affected by drinking contaminated rice wine. More incidents occurred throughout 2011 and 2012. It seems people of all nationalities and professions are becoming victims of 'Arak Attack' or Methanol poisoning. The latest being a 19 year old from Perth, Australia who was poisoned on the island of Lombok on New year's day, 2013. Beer seems to be the safe alternative.

Methanol poisoning is still a threat to tourists and information is hard to come by. Friends and relatives of the victims are using facebook to raise awareness: **www.facebook.com/ADrinkToDieFrom**.
The increased number of cases has caused a travel warning to be placed on the website of the Irish Department of Foreign Affairs as well as the back-packing website Lonely Planet. Relatives including Noel and Theresa will continue to highlight this problem and inform people of the risks by any means necessary. "My family and I never thought we would live the rest of our lives without our treasured daughter. I will do my best to ensure no other parent or family have to experience the heartbreak we feel each minute of every day".

Maria Callaghan

Copies of the booklet

"The Busy Practitioners Guide to TROPICAL MEDICINE"

are available to order from:

Dr. Dom Colbert,
Eleta,
Lower Taylors Hill,
Galway

or

e-mail your order to:

domcolbert@gmail.com

The booklet costs €10.00 which includes packaging and postage.

A limited number of copies will be available to members at our regional meetings for the reduced price of €5.00.

All profit from the sale of the booklet will go to the Medical Missionaries of Mary.

RCSI

The Busy Practitioners
Guide to
TROPICAL MEDICINE

Dom Colbert
MD FRCSI BSc CTHT^{M} FFTM (Glasg) FCS (ECSA)

The Travel Medicine Society of Ireland, Dept. of International Health and Tropical Medicine Royal College of Surgeons Ireland, College of Surgeons of East, Central and Southern Africa, National University of Ireland Galway, Ireland

Any profit from this booklet is donated to the Medical Missionaries of Mary for their work with the sick, the poor and the disabled, in developing countries

WHAT'S IN THE PAPERS? – A REVIEW OF THE RECENT LITERATURE IN TRAVEL MEDICINE

A sincere thank you to the following medical students who completed the new Travel Medicine Research special study module at NUI Galway for compiling this summary of articles they selected from the recent travel medicine literature under my supervision: Khadijah Ariff, Adam Byrne (Group Leader), Luke Forde, Karan Grealish, Muhammad Tariq Haja Mohainuteen, Muhammad Asyraf Maarof, Abirami Manian, Emil Mellgren, Adele O'Mahoney, Henry Roberts, and Malavika Suresh. Students' initials are listed in bold font following the article which they studied. All 11 students are now student members of the TMSI. This literature review will be a regular feature of the 'Taisteal' newsletter from now on and I hope it will help you to keep abreast of the growing evidence base in the dynamic discipline of travel medicine. In general, articles which have been published in the previous year will be given preference.

Detection of Respiratory Viruses Among Pilgrims in Saudi Arabia During the Time of a Declared Influenza A (H1N1) Pandemic

Ziad A. Memish, Abdullah M. Assiri, Raheela Hussain, Ibrahim Alomar, and Gwen Stephens
Journal of Travel Medicine 2012;19(1):15-21

This study focused on pilgrims arriving and departing from Saudi Arabia during the Hajj season, which involves almost 2 million people every year. The aim was to investigate if any association existed between the pilgrim attendance for Hajj season and an increased risk of acquiring influenza and other respiratory viruses. It also aimed to measure the compliance of pilgrims with influenza vaccination and other recommended measures. The study used a cross-sectional survey conducted among pilgrims at the King Abdulaziz International Airport. Nasopharyngeal and throat swabs were taken and sent for laboratory testing. The study revealed that the prevalence of any respiratory-virus infection was 14.5% while the prevalence of pandemic influenza A (H1N1) was 0.2%. However, it was surprising to observe that the level of compliance with preventive measures by the pilgrims was relatively low at 50% despite the high risk of infectious diseases they faced. This study could be criticised because the investigators did not follow the same respondents from arrival until departure. This study demonstrated a very low prevalence of pandemic influenza A (H1N1) among arriving pilgrims and there was no evidence of transmission amplification among departing pilgrims. **KA**

Can Business Road Travel Be Safe? Experience of an International Organization

Jasminka Goldoni Laestadius, Anne Gaelle Selod, Jian Ye, Lennart Dimberg, and Anthony G. Bliss
Journal of Travel Medicine 2011;18(2):73–79

This study was carried out by the World Bank Group (WBG) to identify countries that posed the highest risk to their employees with respect to road travel on business abroad. In the form of a questionnaire generated by WBG, data on the incidence of road traffic accidents in each country of business were generated. To establish relative risk, a formula based on 'person-days' was used. Information on the number of days in total spent in a country was obtained from a Human Resources dataset and the occurrence of road traffic accidents was extrapolated from the respondents' submitted surveys. Summating the number of crashes and near crashes per 1,000 person days, a list of high-risk countries was formed. The roads in Oman statistically posed the highest risk. Respondents had the opportunity to outline the causes for the crashes and near crashes, and to suggest strategies for safer road travel abroad. WBG used the collected data to implement a road safety policy. **AB**

Physiological and Psychological Illness Symptoms at High Altitude and their Relationship with Acute Mountain Sickness: A Prospective Cohort Study

Samuel J. Oliver, Stephan J. Sanders, Catherine J. Williams, Zoe A. Smith, Emma Lloyd-Davies, Ross Roberts, Calum Arthur, Lew Hardy, Jamie H. Macdonald
Journal of Travel Medicine 2012;19(4):210-219

This study's aim was to determine if illness symptoms would increase at high altitude, if certain physiological factors would correlate with these illnesses and to determine if the presence of physical and mental symptoms would relate to acute mountain sickness (AMS). 44 cohorts completed the 19 days Dhaulagiri base camp trek in Nepal, attaining a height of 5372m. An observational prospective cohort study was completed, including a 1 week baseline period at low altitude. Participants self-completed a physical and mental health diary recording illnesses and symptoms using varying Likert scales, including: AMS, stool consistency, anxiety, fluid intake, upper respiratory symptoms (URS), arterial O2 saturation and heart rate. To complete the study's aims, statistical differences between days for
individual symptom scores were determined by ANOVA. Longitudinal linear regression analyses and time lag analyses of three models of AMS as outcome variables and the above symptoms (not AMS) as predictor variables were also determined. Of particular note were the following: all individuals had upper respiratory symptoms at least once and 98% anxiety; URS, heart rate, arterial O2 saturation and fluid intake could predict AMS symptoms the following day. AMS was reported even at low altitude indicating that possible misdiagnosis can occur. This study indicates that more careful diagnosis and thus treatment of AMS is required; it provides causal factors causally related to AMS and provides some insight into possible mechanisms underlying the disorder. **LF**

Substance Use, Violence and Unintentional Injury in Young Holidaymakers Visiting Mediterranean Destinations
Karen Hughes, Mark A. Bellis, Amador Calafat, Nicole Blay, Anna Kokkevi, George Boyiadji, Maria do Rosario Mendes, and Lubomira Bajcarova
Journal of Travel Medicine 2011;18:80-89

The aim of this research was to examine the risks of violence and unintentional injury abroad and their relationships with alcohol and drug use. The research was conducted by survey of British and German tourists in airports across Europe. The survey found that 95% of the respondents consumed alcohol on holidays and over two thirds had been drunk. The most frequently drunk were British travellers in Majorca and Crete. The highest drug use was in Cyprus. Overall 3.8% of respondents were involved in violence and 5.9% reported unintentional injury while abroad. 91.6% of those involved in violence reported being drunk at the time, suggesting a strong temporal relationship. Violence mostly occured in bars, nightclubs or in streets. There was a significant accociation between violence, injury and frequent nightclub attendance. Majorca and Crete reported the highest levels of violence and injury. These locations were mostly chosen for their weather and nightlife, indicating that they attracted visitors looking for entertainment centered around bars and nightclubs, contributing to their higher levels of violence. Having a repuation for drunken behaviour can damage a resort's tourism. By understanding the characteristics accociated with violence and injury, prevention initiatives could be implemented to protect both tourists and the resorts they visit. **KG**

Health Risks of Travelers with Medical Conditions - A Retrospective Analysis
Rosanne W. Wieten, Tjalling Leenstra, Abraham Goorhuis, Miche`le van Vugt, and Martin P. Grobusch
Journal of Travel Medicine 2012;19(2):104-110

An observational study was carried out at the University of Amsterdam's Academic Medical Center's (AMC) travel clinic to determine which groups of travellers with medical conditions had higher risks of travel-related diseases (TRDs) compared to healthy travellers. The purpose of this analysis was to identify areas that could optimise the national guidelines for pre-travel advice in the Netherlands. The study was conducted between January and October 2010 and telephone questionnaires were delivered to 345 individuals with medical conditions and 100 healthy travellers. After obtaining demographic details, the authors examined pre-existing conditions in the patients, the illnesses they reported during travel (TRDs), and their travel destinations. An incidence rate ratio (IRR) was used to analyse the data with healthy travellers being the reference group. The results indicated that impaired immunity due to immune suppressive drugs, HIV infection, reduced gastric acid barrier, and diabetes mellitus were the most common medical conditions with gastrointestinal symptoms reported most frequently. An increased risk of obtaining TRDs was found in Central America, followed by Northeast Asia, South Central Asia and North Africa. Though this study was advantageous in indicating that most TRDs were contracted in Central America, not much was known on the aetiology of the diseases. **AM**

Cutaneous Larva Migrans and Tungiasis in International Travelers Exiting Brazil: An Airport Survey
Jorg Heukelbach, Marcia Gomide, Francisco Araujo,Jr,, Nathalia S.R.Pinto, Rafael D.Santana, Joao R.M.Brito, and Hermann Feldmeier.
Journal of Travel Medicine 2007;14(6):374-380

A cross-sectional study was performed on European tourists by distributing questionnaires at the departure gate of the airport of Ceara State in Brazil where cutaneous larva migrans (CLM) and Tungiasis are endemic. Thr study was undertaken because reliable data on the frequency of CLM and Tungiasis are not at hand as their occurrence is not registered in national infectious disease databases. It was conducted during December which was dry and a peak season for tourists. In this period, the prevalence of Tungiasis was highest but the opposite applies for CLM in northeastern Brazil. The questionnaires included questions on pre-travel health advice, personal characteristics, acquired parasitic skin disease and its clinical characteristics of infestation. Photographs of typical infestations were also presented to help identify CLM and Tungiasis. 82.7% of the questionnaires were answered and the majority of respondents were male. Almost two thirds resided in Portugal, Netherlands or Italy. Only 14% of respondents had sought pre-travel health advice on CLM and 22% on Tungiasis. About 3.2% of respondents were infested with Tungiasis and 0.8% acquired CLM. Lesions were confined to the feet. The risk of being infested by Tungiasis is 20 times more if the length of stay exceeds 2 weeks. None of the tourists decided to visit a travel clinic on return. **MTHM**

Patterns of Measles Transmission Among Air Travellers
Paul J. Edelson
Travel Medicine and Infectious Disease 2012;10(5):230-235

Measles infection among air travellers may be considered a low-risk event. It is due to high level of measles resistance in many countries and the advanced technology used in air management systems on modern aircraft. Criteria for contact investigations for measles exposures are considered contacts to those travellers who are seated within two rows from the index case. However, recent studies have proved that cabin airflow may not be a dependable shield to the spread of measles virus as previously understood. Several reports in this study have explained measles developing after travel in passengers seated within a certain distance from the index case. Articles in Medline and Embase were searched. Nine reports (13 index cases and 23 apparent secondary cases) on 10 flights were reviewed. Separation between the index and secondary cases ranged from adjacent seats to 17 rows. Three flights had more than one index case.
This is crucial in understanding the wider spread described in some of the reports. Although the cabin airflow system is considered highly efficient, concerns have been raised about the effectiveness of the system itself as turbulence is generated in cabin airflow when passengers and aircrews are onboard, permitting the spread of infective agents across many rows. **MAM**

Decrease of Asymmetric Dimethylarginine Predicts Acute Mountain Sickness
Tannheimer M, Hornung K, Gasche M, Kuehlmuss B, Mueller M, Welsch H, Landgraf K, Guger C, Schmidt R, Steinacker JM
Journal of Travel Medicine 2012;19(6):338-343.

Acute mountain sickness (AMS) is a syndrome that occurs in persons ascending to high altitudes (>2500m) without sufficient acclimatisation. Today 40 million tourists worldwide are at risk of getting AMS each year. Research into possible risk factors and susceptibility tests for AMS has become increasingly important. The German Armed forces recently performed a prospective comparative study investigating whether serum asymmetric dimethylarginine (ADMA) measurements at simulated high altitude could predict onset of AMS. ADMA is a potent inhibitor of nitric oxide synthase (NOS) which in turn catalyses the production of nitric oxide (NO). NO is a vasodilator which also plays a key role in oxidative metabolism and modulates the response to hypoxia. As ADMA is an NOS inhibitor, this group predicted that an increased ADMA should increase the risk of AMS development. Surprisingly, they found a negative correlation of Δ-ADMA and onset of AMS symptoms instead of the hypothesised positive correlation. It was also shown that the Δ-ADMA value after 2 hours of hypoxia can predict the development of AMS with a sensitivity of 80% and a specificity of 100% within the next ten hours. Although exciting as a potential new diagnostic method, these findings need confirmation with a larger cohort. **EM**

Management and Control of Varicella on Cruise Ships: A Collaborative Approach to Promoting Public Health
Elaine H. Cramer, Douglas D. Slaten, Adriane Guerreiro, Danisha Robbins, and Andrew Ganzon
Journal of Travel Medicine 2012;19(4):226-232

This unique and fascinating study gives an insight into the prevalence and successful management of the virus varicella on board US passenger cruise ships. In this article the researcher's focus is on the crew members as many originate from varicella-endemic countries where, unlike the USA, there is no varicella vaccination programme in place. The researchers aimed to review varicella case reports from 2005 to 2009, paying attention to control efforts by the CDC and cruise ship company, and analysing whether collaboration between the two leads to successful infection management. They also reviewed varicella reports for 2009, linking cases together as outbreaks and reviewing the response efforts by cruise lines to control and administer post-exposure vaccinations to possible affected. The profile of varicella patients from case reports was not surprising, with 75% coming from Caribbean and Asian countries, the majority (80%) being male. The results were pleasing overall with an excellent response from the cruise ships and CDC towards prevention of further illness, though a suggestion of implementing pre-placement immunity screening was made several times in the article. A more specific clinical definition of varicella, however, may be needed, as the one given by CDC may have been too vague. **AO'M**

Business Travellers' Risk Perception of Infectious Diseases: Where Are the Knowledge Gaps, and How Serious Are They?
Elke Wynberg, Sharyn Toner, Judy K. Wendt, Leo G. Visser, Daan Breederveld, and Johannes Berg
Journal of Travel Medicine 2013;20(1):11-16

This recent study examines the perceived risk in Frequent Business Travellers (FBTs) of acquiring 11 infectious diseases and whether demographic factors, source of travel advice (if any) or the timing of travel preparation influenced this. The researchers used a retrospective, web-based survey to assess this. It was found that while demographic factors did not influence risk perception, FBTs who sought travel advice from their company doctors had a more accurate risk perception for most diseases. FBTs travelling on longer visits were more likely to seek travel health advice prior to departure. While proving an interesting study and being relatable to other literature, there were some flaws with its methodology. The retrospective nature of the survey could potentially skew the FBTs' perception of exposure risk, having already visited their destination country. Survey self-administration may have introduced bias also, with FBTs more confident in their risk assessment being more likely to respond. The responder's immunisation status was not considered, nor was the travel doctor's baseline knowledge level of the risk of disease. Risk perception remains to be an important means of encouraging good prophylactic practices amongst travellers. **HR**

Travel-Related Change of Residence Leads to a Transitory Stress Reaction in Humans
Blasche GW, Weissensteiner K, and Marktl W
Journal of Travel Medicine 19(4): 243-249

The aim of this study was to investigate whether humans show a transitory stress reaction when faced with travel-related change of residence (CoR). The participants were 48 individuals who were travelling to a health resort located 120km away from their hometown. Participants monitored their blood pressure twice a day 3 weeks prior (as a baseline value) and during their 3 week stay at the resort. They also filled out a diary stating their mood and quality of sleep. The changes in the variables compared to the baseline values on the day prior to CoR, the day of travel, the day after their CoR, as well as 5 days after CoR were determined. The results showed that both the systolic and diastolic blood pressure of the participants were increased on the day before travel, and their diastolic BP remained increased on the day of travel and the day after arrival. The quality of sleep suffered on the first night at the new residence. These three variables returned to their baseline measurements 5 days after CoR. Mood was not affected by the change of residence. These results indicate that the anticipation of CoR along with the actual CoR both affect individuals in a transient manner. Results of this study are relevant to tourism, rehabilitation and spa-research. **MS**

CONFERENCE REPORT: 9TH INTERNATIONAL SOCIETY FOR MOUNTAIN MEDICINE WORLD CONGRESS

Dr. Gerard Flaherty is pictured at the ISMM World Congress in Taiwan with Dr. Buddah Basnyat, the new President of the ISMM and Medical Director of the Himalayan Rescue Association.

I travelled to Taipei, capital of the beautiful island state of Taiwan officially the Republic of China, in November 2012 to attend the International Society for Mountain Medicine (ISMM) World Congress. I have been supervising a special study module in high altitude medicine at NUI Galway for years now and I receive regular queries from other travel medicine physicians, GPs and mountaineering guides about the health risks associated with travel to high altitude. It was good to get up to date at this meeting. I had attended the World Congress when it was held in Aviemore, Scotland previously. Taipei was almost as difficult to reach but definitely worth the effort! The city has a pleasant mix of Chinese and western influences, not dissimilar to Hong Kong, but not as developed. The people were polite if somewhat shy but very warm and welcoming. The food of course was delicious although you have to shop around; it's not as keenly priced as you might wish. I got the impression that it was a very safe city from a traveller's perspective.

Departing President Marco Maggiorini from Switzerland handed over the reins to incoming President Buddha Basnyat of Nepal. Because I had recruited 10 student members to the ISMM and because we have a national travel medicine society, Ireland qualified to hold a place on the Executive Council and I was elected to this role at the Annual General Meeting on the basis of my practical and academic experience in high altitude medicine.

The programme opened with a special lecture by Tomotsu Nakamura from Japan who gave a lecture titled East of the Himalaya – The Final Frontier, The Alps of Tibet, and Beyond. Nakamura was recently quoted as saying, "Some convince themselves that veiled mountains in the greater ranges are an experience of the past"...but "Eastern Tibet has an incredibly vast and complex topography that holds countless unclimbed summits and beckons a lifetime's search." Professor John West, editor of the journal High Altitude Medicine and Biology gave a wonderful lecture on the current state of high altitude physiology, from the contribution of molecular biology to our understanding of the adaptation of native highlanders to the oxygen enrichment of train carriages in China and workplaces in the Andes and Hawaii.

Continued on page 18

A series of excellent parallel symposia followed, covering topics such as genes and altitude adaptation, preparing for high altitude exposure, prevention and treatment of acute mountain sickness (AMS), risk evaluation for severe AMS, iron metabolism at high altitude and the pathophysiology, prevention and treatment of high altitude cerebral oedema and high altitude pulmonary oedema. Former President Peter Hackett led a very interesting discussion on climbing "by fair means", which contributed to the debate raging about the use of medications and supplemental oxygen on high peaks. Peter himself, who is based in Colorado in the US, was fascinated to learn from me about Castle Hackett, a 13th century Tower house in Belclare, County Galway, built by the Norman Hackett family who established themselves along the east side of Lough Corrib, having driven the O'Flahertys across the lake to Connemara. I felt suitably conquered by his clan and we enjoyed a good laugh about it over coffee!

Makalu Gau from Taiwan gave a special lecture recounting his experiences as one of the survivors of the famous mountaineering disaster which occurred on Mt Everest in the spring of 1996 and subsequently described by Jon Krakauer in the book 'Into Thin Air'. He gave a fascinating account of his struggle to return to the mountains after suffering from severe frostbite during that terrible tragedy on the world's highest peak.

Further symposia dealt with topics including circulation control at high altitude, metabolic changes at high altitude, exercise at high altitude and athletic training to improve athletic performance. Eric Swenson provided a comprehensive review of the management of pre-existing pulmonary conditions in high-altitude travellers. There were three sets of oral presentations, comprising 13 speakers, with topics ranging from meteorological conditions on the South Col of Everest (8000m) and the risk of hypothermia in extreme altitude mountaineers to experiences in teaching mountain medicine across the world. On the final day there was an interesting session on rescue medicine and the future of telemedicine in mountaineering.

I enjoyed this conference and pledged the support of the TMSI in improving awareness of high altitude and mountain medicine amongst our members through our regional seminars and specialised courses. If you are interested in becoming a member of the ISMM, please visit their website at www.ismmed.org. The current cost for members of the TMSI is approximately €80 with a reduced rate for students or trainees.

Dr. Gerard Flaherty

The Travel Medicine Society of Ireland are now offering Student Membership of the Society to medical students.

Student membership costs €15.00 per annum and students are welcome to attend all our seminar/meetings

We are delighted to welcome our first batch of 11 students to the society.

GLOBAL ROUND-UP

Dengue Fever: Bolivia. As of 25 March 2013, more than 6200 suspected cases of dengue fever have been recorded nationwide. Of those, 1330 have been laboratory confirmed. The worst affected department is Beni in the northeast of the country.

Source: ProMED-Mail

Argentina. As of 30 March, 2870 suspected cases of dengue fever have been recorded nationwide, of those, 181 have been laboratory confirmed.
Provinces most affected include: Salta (75 cases), Cordoba (41), Buenos Aires (34) and the autonomous city of Buenos Aires (19 cases).

Source: ProMED-Mail

Thailand. As of 17 March 2013, 13 000 cases of dengue fever have been reported countrywide during the first three months of 2013. This is four times higher than in 2012.
Many children younger than 14 years of age have reportedly died from dengue fever. The majority of deaths were reported from Songkhla (5) and Nakhon Si Thammarat (2). At least one death has been reported in Bangkok, Samut Prakarn, Nakhon Pathom, Prachuap Khiri Khan, Rayong, Pattani and Yala.

Source: ReliefWeb.int

Solomon Islands. The outbreak of dengue fever in the Solomon Islands is ongoing. As of 12 March 2013, 509 suspected cases have been recorded, of those, 169 have been confirmed as dengue virus infection. One death from dengue fever has been recorded. New cases continue to increase.

Source: ProMED-Mail

New Caledonia. Dengue fever is an ongoing problem in New Caledonia. Since the beginning of the year (2013), 3327 cases have been recorded. Between 15-200 cases have been reported daily. The serotype in circulation is DENV-1.

Source: ProMED-Mail

Avian Influenza: China. On 31 Mar 2013, the China Health and Family Planning Commission notified the World Health Organization (WHO) of 3 confirmed cases of human infection with avian influenza A(H7N9). These are the first recorded human infections with low pathogenic avian influenza A(H7N9).
The cases were reported from Shanghai (2 cases) and Anhui province (one case). All 3 cases presented with respiratory tract infection with progression to severe pneumonia and breathing difficulties.
Disease onset was between 19 Feb 2013 and 15 Mar 2013. Two of the cases died. The 3rd case is currently in critical condition.
To date, no epidemiological link between the cases has been identified. An investigation including follow-up of contacts is ongoing. So far, no further cases have been identified among the 88 identified contacts under follow up.

Source: ProMED-Mail

China. In general there have been fewer cases of Measles in China in 2012, compared with 2011. Some provinces however, have reported an increase in 2012, these include: Hubei, Xinjiang, Guangdong, Qinghai and Sichuan. The worst affected province is Yunnan, with 336 cases in 2012, compared with 109 measles cases in 2011.

Source: ProMED-Mail

Rabies: India. The death of 2 women from rabies virus infection on successive days has raised concerns over the increasing problem of stray dogs in the city of Madurai, Tamil Nadu state in the south of India. The first case, a 55-year-old woman who was admitted to hospital on 12 March 2013, with suspected rabies infection died the same day. The woman had been bitten by a stray dog 2 weeks previously. The second case, a 45-year-old woman who was admitted to hospital on 11 March 2013, with suspected rabies infection also died the same day.
Hospital authorities report that 5 individuals have died from rabies infection in the hospital during the last 3 months, this compares with 12 deaths for the whole of 2012. On average, there have been 10 human deaths from rabies annually over the last 5 years.

Source: ProMED-Mail

Travel Medicine Conference Calendar

Travel Medicine Society of Ireland, A.G.M. & Lecture ***Date:*** 27th April 2013
Location: Red Cow Moran Hotel, Naas Road, Dublin 22 Time: 9:00 am – 1:00 pm
Guest Lecturer: Dr. Mike Jones, Dean, Faculty of Travel Medicine, Royal College of Physicians & Surgeons, Glasgow.
Contact: Anne Redmond, Tel: 045 890 127, E-mail: annehredmond@eircom.net

ICGP Annual General Meeting 2013 ***Date:*** 10th - 12th May 2013
Location: Radisson Hotel, Glaway
Title: Facing current challenges and safeguarding the future of Irish General Practice.
This conference will be hosted with the help of the Travel Medicine Society of Ireland and will include an OSKE session on current travel medicine topics.

13th Conference of the International Society of Travel Medicine
Date: May 19-23, 2013
Location: Maastricht, The Netherlands.
The 13th Conference of the International Society of Travel Medicine is now open for early registration. CISTM 13 will take place in Maastricht which is well served by several airports and regular trains, making it easily and cheaply accessible from Ireland. There is a very full and comprehensive programme suitable for Travel Medicine practitioners of all levels from beginners to experts. Attending meetings such as this is a great way to gain knowledge and experience in a rapidly developing subject. For further information visit: www.istm.org.
Those wishing to obtain a qualification in Travel Medicine can sit the examination for the Certificate of Knowledge in Travel Health on Sunday May 19th. This a one day MCQ exam covering a range of topics which are listed on the ISTM website. Dom Colbert's excellent primer on questions and answers in Travel Health is a great way to revise and prepare. This book was the inspiration for the exam design and is widely quoted for exam preparation. It would be great to have an Irish presence in Maastricht. You will receive a warm welcome following the successful hosting of NETM4 in Dublin and a valuable learning opportunity.

31st Annual Meeting of the European Society for Paediatric Infectious Diseases
Date: May 28 - June 1, 2013
Location: Milan, Italy.
ESPID 2013 Annual Meeting is distinguishable by its innovative scientific programme, interactive case sessions, platform presentations, educational workshops, and ESPID 2013 in Milan will be no different! Focusing on Paediatric Infectious Diseases: Future Prospectives, ESPID 2013 will provide clinical practitioners, researchers and industry professionals' unparalleled access to the latest findings and analysis in the field of paediatric infectious diseases. Abstract submission deadline is January 14, 2013.
For more information visit: www.kenes.com/espid or email espid@kenes.com.

Travel Medicine Society of Ireland 1-day workshop ***Date:*** 22nd June 2013
Location: Sheraton Hotel, Gleeson Street, Athlone, Co. Westmeath.
Time: 9:00 am – 4:00 pm
Price: €45 for T.M.S.I. members. €60.00 for non-members. Includes mid-morning tea/coffee, lunch and mid-afternoon tea/coffee. Places limited, book early.
Contact: Anne Redmond, Tel: 045 890 127, E-mail: annehredmond@eircom.net

Travel Medicine Society of Ireland ***Date:*** 7th September 2013
Location: Rochestown Park Hotel, Cork
Time: 9:00 am – 1:00 pm
Contact: Anne Redmond, Tel: 045 890 127, E-mail: annehredmond@eircom.net

Travel Medicine Society of Ireland ***Date:*** 2nd November 2013
Location: Clarion Hotel, Liffey Valley, Lucan, Co. Dublin
Time: 9:00 am – 1:00 pm
Contact: Anne Redmond, Tel: 045 890 127, E-mail: annehredmond@eircom.net

5th Northern European Conference of Travel Medicine ***Date:*** 5th - 8th June 2014
Location: Bergen, Norway
More details in future newsletters.