

TAISTEAL



Volume 17

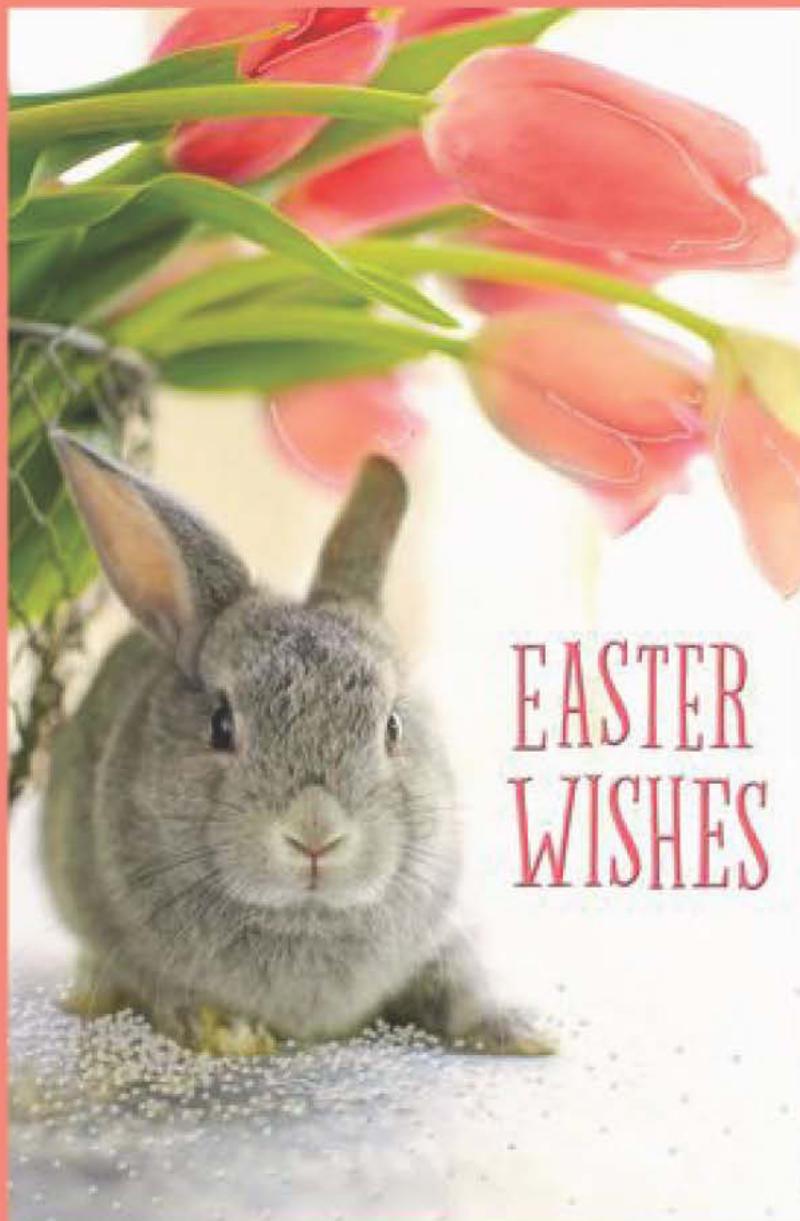
Issue 1

Spring 2017

NEWSLETTER

ed. S. Collins

*The Travel Medicine Society of Ireland
wish all our members a Happy Easter*



We look forward to seeing you in 2017

CAUGHT OUT BY AN ATYPICAL PRESENTATION OF A RELATIVELY COMMON TRAVEL-RELATED SKIN ERUPTION

Post-travel skin eruptions are one of the more common categories of post-travel problems encountered in clinical practice, often ranked as the third most common category of problem after digestive tract upsets and fevers. A patient in his early 30's e-mailed me recently, four days after returning with his wife to Ireland from a three-week holiday to Thailand. It was a Friday evening and he was seeking assistance. His e-mail read:

We came back from Thailand this week - but unfortunately the last night of our travels I forgot to put on a mosquito repellent. This, I believe, resulted in a series of mosquito bites across my back and lower back, which only got worse with every passing day. I tried to use the cream you prescribed before the trip [Betamethasone] on the itchy red bumps, as well as the pills prescribed [Cetirizine e.g. Zirtek], but to no avail.

He included a photo of his back in his e-mail:



Photo 1: patient's back on day 4 post-Thailand – photo sent from home by the patient.

It was Friday evening and I was on my way home. I knew I would not be able to see him until early the following week. I examined the photo close-up and seeing nothing to make me doubt his assessment, I e-mailed him a prescription for a short course of low-dose oral steroids, to calm the apparent insect-bite reaction in his skin. I asked him to contact me the following week if things did not settle.

The patient got back in touch on day 10 post-travel, six days after having initially been in touch with me. The rash was still itchy and had begun to change in appearance. I asked him to come and see me the same day. When he arrived at the clinic, I took a photo of his back:



Photo 2: author's photo of the patient's back on day 10 post-Thailand.

A close-up of one of the marks on his back looked like this:



Photo 3: a close-up of one of the lesions see in photo 2.

The snake-like ('serpiginous') appearance of the red line is the giveaway – the diagnosis is Cutaneous Larva Migrans, or dog hookworm. The sand on which he was lying on the beach in Thailand was contaminated microscopically with infected dog faeces. The worms in the dog faeces penetrated the patient's skin at multiple separate sites on his back and are now 'lost' and migrating aimlessly under the patient's skin. The white spot in the lower part of photo 3 is the entry point for one of the worms and the red track heading upwards represents the track of that worm under the skin.

The patient had significant symptomatic improvement within 48 hours of being given oral Ivermectin and the rash had disappeared with a week.

On day 11 post-travel, the patient's wife presented with a serpiginous lesion that had appeared on her abdomen. She responded to the same treatment.

Commentary:

Cutaneous Larva Migrans (or 'CLM') often presents as one or two intensely itchy lesions on the feet. Widespread distribution on the back is less commonly encountered. The parasite is contracted by direct contact between the skin and contaminated sand or soil and in practice the feet will be most commonly affected but there is nothing to prevent the legs or back or abdomen being affected either, if the patient is sunbathing. Lying on a towel may reduce risk but does not eliminate it, as contaminated sand may end up on the towel (as happened in this particular case).

CLM has a global distribution but is most common in tropical environments, particularly in the Caribbean, Central America and South-East Asia¹.

CLM is not sinister, in that the parasite does not migrate further into the body but it is very uncomfortable for the patient because of the pronounced itch provoked by the immune response in the patient's skin to this migrating foreign entity. The diagnosis is often missed initially – a patient presents to their doctor post-travel with an itchy non-resolving rash that is not responding to topical steroid creams but if the physician is not familiar with the characteristic appearance of CLM, they will not succeed with the normal treatments they use for insect-bite reactions.

Several treatment options exist: Ivermectin in a single dose of 200 micrograms per kilogram body weight will work² (the treatment dose in this case was 15mg as a one-off dose). An alternative is oral Albendazole (400mg daily by mouth once daily for four days).

Learning points - features that suggest a possible CLM diagnosis:

- Itchy rash occurring during holiday or within a few days of return from holiday
- Serpiginous appearance (see photo 3), usually advancing by a few millimetres per day
- Discrete lesions, most commonly on the feet but potentially anywhere the skin was in direct contact with sand or soil
- Non-response of the rash to commonly used over-the-counter treatments
- If asked, the patient will often confirm that the affected area of skin was in direct contact with sand or soil (e.g. walking barefoot or sunbathing)

References:

¹Leder K et al, GeoSentinel Surveillance of Illness in Returned Travelers, 2007 -2013 Ann Intern Med 2013 Mar 19;158(6):456-68. doi: 10.7326/0003-4819-158-6-201303190-00005.

²Ashton R, Leppard B & Cooper H Differential Diagnosis in Dermatology (4th ed.) Radcliffe Publishing 2014.

Dr. Simon Collins FFTM RCPS (Glasg) DTM
(All photos used with the patient's permission).

Foundation and Diploma Courses in Travel Medicine



ROYAL COLLEGE OF
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TRAVEL MEDICINE

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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

ann.mcdonald@rcpsg.ac.uk | clare.henderson@rcpsg.ac.uk

+44 (0)141 227 3239

Travel Medicine Courses, Faculty of Travel Medicine
Royal College of Physicians and Surgeons of Glasgow
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TEST YOUR KNOWLEDGE – MULTIPLE CHOICES QUESTIONS IN TRAVEL MEDICINE:

1. **Altitude Sickness:**
 - A. Commonly affect travellers from 3000 feet above sea level.
 - B. Best way to avoid altitude sickness is to ascend gradually.
 - C. To prevent symptoms of altitude sickness, acetazolamide should be started on reaching the peak altitude.
 - D. High altitude pulmonary oedema and high altitude cerebral oedema are best managed at peak altitude.

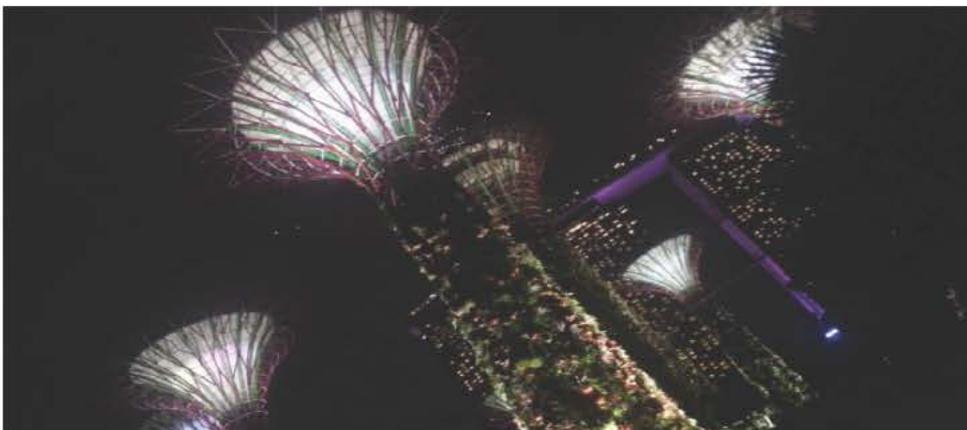
2. **Hepatitis A:**
 - A. Hepatitis A is transmitted through contact with blood or body fluids of an infected person.
 - B. More than 80% of adults with Hepatitis A have symptoms but majority of children do not.
 - C. Single dose Hepatitis A vaccine provides long term immunity.
 - D. Hepatitis A symptoms usually appear from 2-6 days after exposure.

3. **Zika:**
 - A. Is spread mostly by the bite of an infected Aedes mosquito.
 - B. Best prevention is through pre-exposure vaccination.
 - C. Pregnant women whose male partners travel to affected areas should use condoms during sexual intercourse for the duration of their pregnancies.
 - D. An estimated 3 out of 4 people infected with Zika are asymptomatic.

4. **Rabies:**
 - A. 40% of people bitten by suspected rabid animals are children under 15 years.
 - B. Rabies immunoglobulin is required for all cases of contact with suspect animals.
 - C. Transmission can occur when infected material eg saliva comes into contact with human mucosa or fresh wounds.
 - D. Standard pre-exposure vaccination against rabies consists of 3 doses of vaccines given over 3 months.

5. **Malaria:**
 - A. Pregnant women have increased susceptibility to P falciparum.
 - B. Malaria is the most likely cause of fever in return travellers from HoChiMinh City (Vietnam).
 - C. Mefloquine (Larium) has been taken off the market in Ireland.
 - D. Atorvaquone-proguanil (Malarone) is not recommended for children less than 5kg or pregnant women.

6. **What city is this?:**



(Hints:

- Dengue Fever & Hand-Foot-Mouth Disease are common infections in this country.
- Famous & popular foods here include chili crab & “otak-otak”.
- This country is supposedly where the southernmost point of Continental Asia is located.)

Questions set by Dr. Joseph Sim
Answers on page10

WHAT'S IN THE JOURNALS?

In this issue of Taisteal, I will offer a synopsis of the highlights from articles published in the most recent issues of the two leading travel medicine journals. Access to Travel Medicine and Infectious Disease (TMID) is free for Affiliates, Associates, Members and Fellows of the Faculty of Travel Medicine, and ISTM members enjoy free access to Journal of Travel Medicine (JTM), but both journals are available in most Irish university e-libraries. If any TMSI member has an idea for a research project, review article, perspective or commentary-type article, or just a letter to the editor, please email me and I will be happy to advise you. TMID has the highest impact factor of any travel medicine journal and articles appear online shortly after being accepted for publication.

The review process for both journals is rigorous but fair. The rejection rate is typically about 50% for journals of this quality. An article may be accepted with minor revision, major revision, rejected for resubmission, or just rejected. The review process helps to shape the article into a higher quality contribution. It takes experience to learn how best to address points made by reviewers and indeed to stoically accept the fate of the manuscript if it is rejected! Reasons for rejection vary, but include fundamental methodological flaws or lack of acknowledgement of limitations of a study, poor writing, lack of novelty or relevance to the journal's audience, limited critical discussion of the study findings in the context of the existing literature, and inadequate referencing. If there is a demand from our members, I would be delighted to offer an OSKE workshop on "How to write and submit a travel medicine research paper" at one of our regional educational seminars. Perhaps we might arrange this for each of the 2017/18 seminars.



The September-October issue of TMID had 90 pages of interesting material, mostly covering travel-related infectious diseases. Two systematic review articles (the highest form of evidence on a subject) addressed the long-term effects of chikungunya virus disease and antimicrobial resistance among refugees. The chikungunya paper reviewed 37 studies and concluded that the virus exacts a significant toll on patients' quality of life, with arthralgia, arthritis, alopecia and depression being the most common sequelae of infection in these travellers. The refugee paper identified 17 articles which met their inclusion criteria for analysis. Antimicrobial resistance among several species of bacteria was reported and a recommendation was made for improved resistance control measures in the refugee and asylum seeker population.

A study from India reported an incidence of 11% (n=977) of symptomatic returned Hajj and Umrah pilgrims, 300 of whom agreed to participate in the study. No pilgrim tested positive for Middle East Respiratory Syndrome Coronavirus (MERS-CoV) but 11% (n=33) were positive for three different strains of influenza viruses. The authors emphasise the importance of preventive influenza vaccination in this population of travellers.

A prospective, randomised trial of 400 French military troops deployed in Africa investigated the hypothesis that alcohol-based hand rubs reduce the incidence of acute diarrhoea during military deployments. Their results found no significant difference between the hand rub and the "usual hand hygiene recommendations" control group after controlling for confounding factors. The researchers concluded that supplying soap and good quality water in the field should remain a priority. A welcome return to the basics!

With all of the recent focus on Zika virus infection, a group from Colombia wrote a very interesting letter to the editor exploring the potential for outbreaks of emerging arboviral pathogens in Latin America, in

addition to dengue, chikungunya and West Nile virus with which you will already be familiar. Have you heard of Venezuelan equine encephalitis virus, Oropouche virus, and Mayaro virus? The latter has been reported in Trinidad and Tobago, French Guiana, Brazil, Venezuela, Peru, Bolivia, Costa Rica, Guatemala, Panama and Mexico. Mayaro virus infection causes a range of symptoms including fever, headache, myalgia, rash and arthralgia of large joints. The authors consider epidemiologic evidence in relation to this mosquito-borne viral infection and predict a novel threat for an epidemic outbreak in the Caribbean and wider Latin American region. We should watch this space.

The Diagnostic Challenge section of TMID always throws up interesting case reports and this issue features a rare example of a 20-year-old man born in Mayotte who presented with a hard, tender, well demarcated, disfiguring, subcutaneous mass on the left side of his face, causing left nasal obstruction. The final diagnosis was conidiobolomycosis, an invasive tropical fungal infection of facial soft tissue, which is reported to occur mostly in India, Nigeria and Brazil. The causative organism, *C. coronatus*, is found in soil and causes infection in the nasal mucosa by inhalation or direct inoculation. Delayed diagnosis leads to facial tissue scarring. Very few cases have been reported previously in the Comoros islands.

Dieter Stürchler from Switzerland presents a very interesting Serendipity article on the Samoan island archipelago. These “islands in the sea” were settled by Polynesians as recently as 750-300 BC. Samoa lies near the western branch of the Polynesian triangle, comprising Hawaii to the north, New Zealand in the southwest and Easter Island (Chile) in the southeast. After World War I, German Samoa became Western Samoa under New Zealand rule, before gaining independence in 1962. In 1997, the official name was changed back to Samoa. As travel medicine practitioners, we should endeavour to have a strong knowledge of world geography and the cultural influences at play in our travellers’ destinations. I have never visited Polynesia, but if any of our TMSI members have, we would be delighted if you could present an OSKE workshop on this exotic destination at one of our regional educational seminars.



There have been two issues of JTM already in 2017. In the curiously labelled first “March/April 2017” issue, Kim et al. reported the findings of a retrospective study examining the incidence and types of inflight medical incidents between 2009 and 2013. There were 15 inflight deaths and 15 flight diversions during this period. First aid was administered in approximately half of the cases by cabin crew and in the remaining cases by medical volunteers. The most common incidents requiring treatment were burns and syncope. This will come as no surprise to anyone who has tried to drink a cup of tea or coffee during air turbulence on board an airplane! For those who want to learn more about air turbulence-related injuries, I wrote a letter to the editor on the subject which appears in the current “May/June 2017” issue of JTM. With global warming, it is anticipated that we will experience more frequent and more severe clear air turbulence during air travel. Fasten those seatbelts, even when the sign is not illuminated!

Karin Leder from Melbourne reports the findings of an interesting practice-based survey of travellers’ diarrhoea, reported by 364 respondents in 23 countries. There was greater variability in the approach taken by travel medicine practitioners in recommending self-treatment of moderate travellers’ diarrhoea than mild or severe cases.

I worked with Prof. Denis Cusack from UCD on a review article dealing with the repatriation of human remains following death in international travellers – a distressing but very important, and often overlooked

dimension of overseas travel. I am hoping to purchase open access for our article so that I can make it available to our TMSI members. The abstract is reproduced with permission below.

Repatriation of human remains following death in international travellers

Ruairi Connolly, Richard Prendiville, Denis Cusack, Gerard Flaherty

J Travel Med (2017) 24 (2): taw082.

Abstract

Background: Death during international travel and the repatriation of human remains to one's home country is a distressing and expensive process. Much organization is required involving close liaison between various agencies.

Methods: A review of the literature was conducted using the PubMed database. Search terms included: 'repatriation of remains', 'death', 'abroad', 'tourism', 'travel', 'travellers', 'travelling' and 'repatriation'. Additional articles were obtained from grey literature sources and reference lists.

Results: The local national embassy, travel insurance broker and tour operator are important sources of information to facilitate the repatriation of the deceased traveller. Formal identification of the deceased's remains is required and a funeral director must be appointed. Following this, the coroner in the country or jurisdiction receiving the repatriated remains will require a number of documents prior to providing clearance for burial. Costs involved in repatriating remains must be borne by the family of the deceased although travel insurance may help defray some of the costs. If the death is secondary to an infectious disease, cremation at the site of death is preferred. No standardized procedure is in place to deal with the remains of a migrant's body at present and these remains are often not repatriated to their country of origin.

Conclusions: Repatriation of human remains is a difficult task which is emotionally challenging for the bereaving family and friends. As a travel medicine practitioner, it is prudent to discuss all eventualities, including the risk of death, during the pre-travel consultation. Awareness of the procedures involved in this process may ease the burden on the grieving family at a difficult time.

The epidemiology of *Clostridium difficile* infection among travellers is poorly understood and factors such as antibiotic use and change in the gut microbiota could increase the risk of this disease among travellers. The GeoSentinel Surveillance Network analysed 187 eligible cases of *Clostridium difficile* infection in non-immigrant international travellers aged >2 years, seen <12 weeks post-travel. The largest proportion of ill travellers had travelled to Asia (31%), Central/South America or the Caribbean (30%), and Africa (24%). The most commonly used diagnostic test was *C. difficile* toxin gene PCR. The authors conclude that their data underscore the importance of awareness of *C. difficile* as a potential cause of travel-associated diarrhoea. In the same issue of JTM the GeoSentinel Surveillance Network also reported a retrospective analysis of travel-related cases of pertussis. There were 74 cases in the GeoSentinel database over a 16-year period, with a median age at diagnosis of 44 years. Cases from India and China predominated with 10 cases each. Ninety-five percent of patients had respiratory symptoms, while fatigue and fever were described in 28% and 27%, respectively. Immunisation status against pertussis was unknown. Most cases (93%) were reported after 2005. The pre-travel consultation provides an opportunity to verify routine immunisation status and provide vaccine boosters against diseases such as pertussis which is becoming increasingly recognised as a threat to international travellers.

A retrospective review of medical evacuation data of Shell International (oil and gas industry) employees – expatriate employees and frequent business travellers – between 2008 and 2012, found a Medevac rate of 4 per 1000, with 16 per 1000 for females and 3 per 1000 for males. The most frequent reasons for evacuation related to traumatic and gastrointestinal emergencies. In 9% of cases, there was a definite link between the diagnosis requiring Medevac and a pre-existing medical illness. Medevacs were highest from countries classified as high risk or extreme risk.

Riddell and Babiker conducted a 6-year retrospective review of laboratory-confirmed cases of dengue fever in East London between 2010 and 2016. Forty-four cases (40 from three acute hospitals and 4 from primary care clinics) were confirmed by viral RNA and/or IgM detection, 13.6% of whom had secondary infection. Median age was 34 years with the majority of cases occurring in male patients (68.2%). Over 80% of returned travellers were non-white, with South Asia as the most frequent travel destination followed by Southeast Asia. The seasonal peak occurred in July-September (43.2%). One case satisfied the WHO criteria for severe dengue infection. By comparison, the Health Protection Surveillance Centre received 15 notifications of dengue fever in Ireland in 2013 (Source: <https://www.hpsc.ie/A-Z/Vectorborne/LymeDisease/EpidemiologicalData/File,15266,en.pdf>). We need to be vigilant for the possibility of dengue infection in febrile returned travellers. A comprehensive travel history is essential. I advise patients to record any symptoms they experience during travel and to take photographs of any skin rashes to aid in differential diagnosis during travel or later if they present with symptoms upon return.

You may remember I presented an OSKE in Athlone in 2016 on the subject of blood donations and international travel. This was the subject for a Perspective article of mine which was published in the most recent issue of JTM. The article describes the restrictions placed on returned travellers in relation to donation of blood and the transfusion screening protocols in place around the world. The article focuses on malaria, Chagas disease, West Nile disease, Yersiniosis, Babesiosis, Hepatitis E and Visceral Leishmaniasis. A second Perspective article in the same issue of JTM describes the dangers of carbon monoxide poisoning in travellers. It relates the tragic case of the death of a young Irish man who had been travelling in Argentina, where he succumbed to fatal carbon monoxide poisoning from a lit stove in his room. The article analyses the risks of carbon monoxide poisoning in other accommodation scenarios, during winter travel, and in adventure tourists such as cavers and mountaineers. A case is made for the use of portable carbon monoxide detectors in travellers. I use one such device during international travel, purchased online for £18.85 sterling.

Finally, perhaps on a lighter note, a letter to the editor from two of my medical students and myself warns intending golf tourists about the potential dangers of playing golf on unfamiliar foreign courses. Consider the risks of malaria, sunburn, dehydration, thunderstorms, drowning in lakes (from trying to retrieve lost golf balls), envenoming from snake bites, leptospirosis and Lyme disease from tick bites. One of my co-authors, Dr. Mike Jones, former Dean of the Faculty of Travel Medicine in Glasgow, has taken up golf himself in recent years and is making good progress. We included mention of the adder, *Vipera berus*, the UK's only venomous snake, which can be a threat to unwary golfers in Scotland in early spring. One of the articles I cited in our letter was another letter, this time to the Lancet in 1993. Entitled simply 'Malaria and golf', it was written by none other than our own Dr. Graham Fry, co-founder of the then Irish Society of Travel Medicine. Ours was therefore the second article on the subject of golf travel health risks in the medical literature – Fore!

Prof. Gerard Flaherty

ANSWERS TO TEST YOUR KNOWLEDGE QUIZ FROM PAGE 6

1. Altitude Sickness: A – False / B – True / C – False / D - False
2. Hepatitis A: A – False / B – True / C- False / D - False
3. Zika – A – True / B – False / C – True / D - True
4. Rabies – A- True / B – False / C- True / D - False
5. Malaria – A – True / B – False / C – True / D – True
6. Singapore

TRAVEL MEDICINE SOCIETY OF IRELAND

AGENDA A.G.M. Lecture & OSKE Session

Saturday 29th April 2017

Carysfort I Suite, Talbot Hotel, Stillorgan Road, Stillorgan, Co. Dublin

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A.G.M. of the Travel Medicine Society of Ireland – Members Only

- 8.45 a.m. Registration**
- 9.00 a.m. President's Address – Dr Conor Maguire**
- Apologies & Attendance**
- Approval of minutes – AGM 25th April 2015**
- Report by Hon. Secretary / Hon. Treasurer – Mrs. Anne Redmond**
- Election to Executive Council**
- Presidents business**
- Any other business**
- Date of next Annual General Meeting – 2018 TBA**

* * * * *

LECTURE - OPEN TO ALL

- 10.00 a.m. Presentation of the Dom Colbert Essay Prize by the winning author**
- 10.30 a.m. - 10:50 a.m. Tea / Coffee**
- 10.55 a.m. - 11:55 a.m. OSKE Session 3 x 20 minutes**
- Destination - Travel to South East Asia – Dr. Joseph Sim**
- Rabies – Dr. Astrid Weidenhammer**
- Legal responsibilities in running a yellow fever clinic – Nr. Siobhan Grehan**
- 12.00 a.m. Introduction of Guest Speaker Nr. Sandra Grieve – Dr Conor Maguire**
Lecture entitled: “THINKING BACK – LOOKING FORWARD, A TRAVEL MEDICINE JOURNEY”
- 1.00 p.m. Concludes**

* * * * *



Sandra Grieve is an independent travel health practitioner, active in nurse education.

She is a previous Chair and current member of the RCN Public Health Forum representing the RCN on travel health related issues.

Chair of the NECTM Steering Group she has been involved in the organisation of the NECTM6 conference in London 2016.

Recognised for CPD & Category 1 approval for nurses

SHERPA



This is Ang Chhongba Sherpa and as his name suggests, he belongs to the Sherpas of Nepal.

I first met Ang Chhongba in March 2016. He had just finished a degree in Sociology in Kathmandu and was engaged to be married. He was employed by *Adventures Alternative*, a company that arranges trekking in Nepal. I booked their services to visit the Annapurna district. This is without doubt one of the most beautiful and dramatic landscapes on the planet. It has been called the Earth's third icecap due to the endless expanse of snow-capped mountains. There was a guide for the group and a porter for each trekker. Ang Chhongba was hired to accompany me and cheerfully carried my bag for a week. I was allowed a maximum weight of 15kgs but still felt a tinge of guilt allowing this young man to carry my luggage. I was reminded that every time a tourist comes to Nepal, a local gets a job. We walked an average of 16 to 20km per day with a vertical climb of up to one thousand metres. I was glad to have someone carry my bag!

Ang Chhongba spends two months every year, employed as a porter on expeditions to Everest base camp. He was there at midday on the 18th of April 2015 when the earthquake struck. An avalanche swept through the camp. Ang Chhongba was swept several hundred metres downhill and survived with only bruises. The camp was destroyed, but he helped treat the injured and assisted over one hundred seriously ill climbers who were evacuated in the following 24 hours. He then walked down with no more than the clothing on his back. Ang Chhongba was never paid for his two months' work on the mountain. A different company employed him for that event. They refused to pay his wages because all their tents and gear were lost and no climbers managed to summit that season. This is a common occurrence. There are many unscrupulous companies who charge very large fees for trekking and climbing expeditions. Most employ local staff and pay good wages. Unfortunately, some do not. I met others like Ang Chhongba who were short changed on wages. Some porters carry loads equal to their own body weight wearing only rubber sandals. Others are charged for their food and lodgings while on the trek. If advising trekkers, I always suggest they get advice and recommendations before choosing a trekking company.

Those of us fortunate enough to visit these regions have a responsibility to the environment and people who live there. Many visitors to Nepal walk alone. It's not that difficult to follow a trail and there are many lodges along the way where you can find food and shelter but this is false economy. I prefer to hire porters and guides, it costs a little bit more, but this is their livelihood. Always make sure you use an ethical company rather than

locals touting for business outside your hotel. That way, the people hired will be vetted and trained and you will be in good hands. Our guides told us wonderful stories and showed us rare flowers and wildlife we would have walked past otherwise. They planned our day for us, arranged permits and included rest stops along the way. At the end of each day, we only had to sit down, admire the view and a cup of tea was handed to us.

Sherpas originally lived in Tibet but migrated south into Nepal in the 15th century in response to trade, particularly in salt. They settled in the Khumbu district to the east around Tengboche, on the Everest route used by trekkers today. Sherpas today make up less than one percent of the population of modern day Nepal, large numbers live abroad in North America and more recently the UAE. Most use Sherpa as a name on official documents, leading to believe that a Sherpa is not only an ethnic description but also a noun describing any person who acts as a porter or guide to trekkers and climbers. Because Sherpas live and grow up around the Everest region, they are frequently employed as guides and porters. Sherpa Tensing Norgay and Edmund Hillary were the first to summit Mt Everest.

Ang Chhongba Sherpa was leading a climbing expedition last September when he was setting safety lines for his group. One of the ropes broke and he fell four hundred feet to his death, aged only 23. I was notified through Facebook and was deeply touched by the messages of sympathy from all over the world. He had touched the lives of a great many people. He put his own life in danger so that others could experience the awesome beauty of his homeland. He died so that group he was leading would not be at risk. His legacy reminds us that wilderness travel is not without risk even with skillful guides. Travelers should use reputable agencies, be prepared and respectful of the people and the environment they are visiting. A good guide knows the environment and the risks and will keep you safe even if it means putting themselves in harm's way. Further information about Sherpas and the work to improve their lives and can be found on <http://www.mountain-trust.org>

Dr. Conor Maguire

TRAVEL MEDICINE SOCIETY OF IRELAND
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WHAT TYPE OF TOURIST ARE YOU?

In travel medicine, we often focus on the health needs of particular categories of tourists. Thus, you will all be familiar with responsible tourism, medical tourism, extreme tourism ecotourism, romance tourism, wine tourism, and sports tourism. The topic of my presentation at the Extreme Travel symposium at the CISTM15 conference in Barcelona in May is space tourism. *Adjectival tourism* describes a wide range of mainstream and rather unusual types of tourism, some of which are bound to take you by surprise.

Have you heard of **aerotourists**, for example? These are odd souls who spend a day in an airport enjoying its facilities without ever flying anywhere. **Alphatourism** is a type of **experimental tourism** in which a tourist finds the first street alphabetically on a map, and then the last street alphabetically, draws a straight line between them, and proceeds to walk the path between the two points. Have you ever considered **alternating travel**? This involves leaving your home on foot, taking the first road to the right, then the next on the left, then the next to the right, then the next on the left, etc. The traveller carries on until something, perhaps a building or a stretch of water, blocks their path and they can go no farther. This may not always end well.

Bartender tourism is bound to appeal to the more bibulous traveller. This involves visiting a bar, asking the bartender where their favourite bar is and what they prefer to drink there. You then visit that bar, do the same with the bartender there, and continue on, possibly until somebody puts you in a taxi and sends you home. With **contretourism** the tourist visits a famous tourist site, but turns their back on the site and takes photos of, or just beholds, the view from that direction. If that is not quirky enough for you, you should try **ccitourism**, but you must let a trusted friend or partner walk you blindfolded around a tourist location, describing the sights to you. **Nyctalotourists** only visit tourist attractions between dusk and dawn, when the female Anopheles mosquito feeds. Those who engage in sagittatourism throw an arrow - often a dart arrow - on a map, and travel to the place the arrow hits on that map.

My personal favourite has to be **travel pursuit** although I am not brave enough to ever try it. With travel pursuit, you follow some friends surreptitiously when they go on vacation, not letting them out of your sight. This is where it gets a little creepy folks. You take lots of photos of them using a tele-photo lens. On their return home, you then welcome them – paparazzi style - with a slideshow of their holiday. You do not need to be a travel medicine expert to anticipate the health risks associated with this particular category of returned traveller!

Prof. Gerard Flaherty

Dates for the Diary

TRAVEL MEDICINE SOCIETY OF IRELAND - A.G.M. & LECTURE AND WORKSHOP Date: 29 April 2017

Location: Talbot Hotel, Stillorgan Road, Stillorgan, Co. Dublin.

Time: 9:00am - 1:00pm. A.G.M. Members only. Lecture and workshop open to non-members.

Places limited. For further information, please contact Anne at 045 890 127 or annehredmond@eircom.net

THE 15TH CONFERENCE OF THE INTERNATIONAL SOCIETY OF TRAVEL MEDICINE. Date: 14-18 May 2017

Venue: Barcelona, Spain For further information contact: www.istm.org

TRAVEL MEDICINE SOCIETY OF IRELAND - HALF-DAY MEETING Date: 23 September 2017

Location: Castletroy Park Hotel, Limerick

Time: 9:00am - 1:00pm. Places limited

For further information, please contact Anne at 045 890 127 or annehredmond@eircom.net

TRAVEL MEDICINE SOCIETY OF IRELAND - FULL-DAY MEETING Date: 11 November 2017

Location: Clarion Hotel, Liffey Valley, Dublin

Time: 9:00am - 1:00pm. Places limited. Cost: Members €50.00 & non-members €65.00. Includes coffee breaks and lunch.

For further information, please contact Anne at 045 890 127 or annehredmond@eircom.net

GLOBAL ROUND-UP

MENINGITIS: As of 4 April 2017 the Nigerian Ministry of Health reported a total of 2,997 suspected cases (336 deaths) of cerebrospinal meningitis in 16 States: 146 cases are laboratory-confirmed.

Advice for Travellers: Spread through airborne droplets and direct contact with nasal/pharyngeal secretions of infected individuals or carriers. Meningococcal disease is found worldwide but epidemics may occur in this country, which lies within the extended meningitis belt of Africa, particularly during the dry season. If vaccination is recommended, quadrivalent conjugate vaccine should be used.

Consider vaccinating:

Travellers who are likely to have close, prolonged contact with the local population.

Long stay travellers.

Those visiting friends and relatives.

Those attending mass gatherings (e.g. Hajj or Umrah, festivals, stadia).

Those who will be exposed to municipal crowded areas (e.g. schools, dormitories, hospitals).

Travellers visiting an area affected by an ongoing outbreak or epidemic.

Immunocompromised travellers (including asplenia) visiting endemic areas.

Source: Nigerian MoH

DENGUE FEVER: Sri Lanka: A media report of 1 April 2017, quoting health officials, is advising that there have been 26 000 patients diagnosed with dengue fever over the course of this year. Nearly 50% of the patients were reported from the Western Province. Fifty three individuals have died in the last 90 days.

Vaccine

There is no vaccine against dengue fever licensed in the UK.

Dengvaxia®, developed by Sanofi Pasteur MSD, is the first vaccine to be licensed in the world for the prevention of dengue.

Mexico, Costa Rica, the Phillipines and Brazil are the first countries to have granted marketing authorization for Dengvaxia®

At present the World Health Organisation (WHO) is trialling several candidate vaccines against dengue fever.

Source: News 1st Digital

YELLOW FEVER: Brazil: There has been a further update from WHO (4 April 2017) on the risk of yellow fever transmission in Brazil. As a result, vaccination recommendations for travellers have been extended to include the entire State of Rio de Janeiro, including the city of Rio itself, and the entire State of São Paulo, except the urban areas of São Paulo city. These changes have been incorporated into the Brazil country page on TRAVAX. The determination of new areas considered to be at risk for yellow fever transmission is an ongoing process and updates will be provided regularly. Yellow fever vaccine is recommended for travellers at risk.

Source: WHO

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