TAISTEAL

Travel Medicine Society of Ireland

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NEWSLETTER

ed. A. Weidenhammer

REFLECTIONS ON THE RECENT WORLD TRAVEL MEDICINE CONFERENCE

(16TH CONFERENCE OF THE INTERNATIONAL SOCIETY OF TRAVEL MEDICINE – 'CISTM16'), WASHINGTON D.C. (5TH – 8TH JUNE 2019)

Simon Collins was one of over 1,000 delegates who attended the recent CISTM meeting in the U.S. Here, he shares the experience of attending a large Travel Medicine meeting in an interview with Taisteal editor, Astrid Weidenhammer.

Capitol Hill (pic: S. Collins)

Was this your first big Travel Medicine meeting?

No – I've done this type of trip a few times: Vancouver (2007), Boston (2011), Maastricht (2013) and Québec City (2015). The ISTM holds this conference every two years an up to now, it has rotated between a European and a North American venue. For some time, there have been rumblings about the need to broaden the choice of location in order to better reflect the global nature of the ISTM's membership. As a result of that, the 2021 conference will be in Kuala Lumpur.

What's the attraction of going?

The big draw is an academic one – for three of four days, there are sessions running from 8.00am to 6.00pm where there's a programme that has been designed by the Local Organising Committee (LOC) to cover as many of the current, topical issues in Travel Medicine as possible. You come away feeling very up-to-date with the latest thinking, some of which will not be published in the journals for months to come. Most of the leading thinkers and researchers in Travel Medicine from around the world are in one venue for a few days. Many of them are giving presentations and the set-up is informal enough to enable you to approach any of the speakers afterwards and ask questions or exchange ideas. Over the course of the conference, you can accumulate anything from 15 to 20 external CPD credits.

Who attends?

It's a real global gathering, reflecting the ISTM's membership, although that is dominated by North America and Europe. The breakdown of membership is roughly as follows: U.S./Canada 58%, Europe 20%, Australia/New Zealand 9%, Asia 9%, Africa/Middle East 2.5% and Latin America 1.5%. Everything is conducted through English. You'll be meeting people from Taiwan, Nepal, South Africa, Japanese doctors working at their embassies in Guatemala or Ivory Coast, single-handed practitioners from provincial Polish cities, Israeli hospital specialists and nurses from Swedish travel clinics. There'll be people working in occupational medicine (mining sites from Papua New Guinea to Mozambique), nurses running travel clinics for the staff of the World Bank in Washington and researchers from Belgian universities presenting original work on Rabies post-exposure treatment. It's really interesting to hear about the day-to-day challenges they all face in their work and to get a sense of how Ireland measures up in terms of the way in which we deliver Travel Medicine services and the standard of how we do it.

How does Ireland measure up?

Pretty well. While our impact in terms of research compared to many countries is modest, I do think the day-to-day delivery of Travel Medicine in Ireland scores very well in terms of ease of access for patients and the core knowledge base of nurses and doctors in Ireland.

What's the set-up of the conference?

ISTM typically holds the conference at a large hotel which has a conference centre attached. A lot of delegates will stay at the hotel. Some will stay at neighbouring hotels, guesthouses or internet rentals. There'll be a large ballroom for plenary sessions, which later in the day is divided into smaller rooms. There'll also be a large exhibition room which serves three purposes – a display area for research posters (over 100 on display this year), coffee breaks/mingling and a display area for commercial attendees (pharma companies, travel software providers, academic publishers, travel accessory providers). The meeting programme this year was run through a mobile phone app, where you could plan which sessions you would attend and work out which room you should be in at which time. There was free wi-fi. A free take-away lunch is provided each day, sponsored by one of the pharmaceutical companies.

Washington Hilton Hotel (pic: Hilton, file image)

How are the teaching sessions structured?

Each of the three to four main days has a large plenary session from 9.00 – 10.30am. The LOC will have chosen a theme for each plenary which is designed to be of interest to all attendees. Smaller workshops precede (8.00am – 8.45am) each plenary. 90-minute symposia or workshops follow the plenary, with one before lunch and two in the afternoons. Long coffee breaks are interspersed throughout the day, which gives everyone a chance to mingle, take a break and choose what session to attend next. There are typically four simultaneous symposia running at any one time in thet morning or during the afternoon, so you can choose to attend the sessions that are of greatest interest to you personally. Some of these sessions will involve presentations of original research or else workshops facilitated by experts in a particular topic. The plenary session at the start of the day will have up to 1,000 people in the hotel ballroom. The workshops and symposia will typically have 100 – 150 people attending, with opportunities to ask questions during and after the sessions.


Plenary session (pic: S. Collins)

What were the big plenary sessions focussed on this year?

Climate Change (Thursday 6th), Antibiotic Resistance (Friday 7th) and 'Finding Truth in a Digital Age' (Social Media and Fake News in Travel Medicine, Saturday 8th).

What were some of the big 'take-aways' for you from the conference?

I'll cover some of these at an OSKE session I'll be delivering at the next TMSI meeting in Athlone [21st September 2019 – see www.tmsi.ie] and they include:

- Chikungunya virus and the risks associated with it if contracted during late pregnancy (up to 15% of these pregnancies will have congenital complications)[1] – this is something I had not been highlighting to pregnant

travellers before now

- Influenza and the fact that the annual risk of having a symptomatic episode for children is 1:10 and for adults 1:20 – should we be using this vaccine more in travellers who are not in the traditional at-risk groups? [2]
- Probiotics, prebiotics and the lack of their efficacy in most cases in preventing travellers' diarrhoea[3]
- A reminder that a dose of MMR vaccine can be appropriate for children as young as 6 months of age if they are travelling[4]
- About 5% of patients seen at Irish Sexual Assault Treatment Units have been assaulted while abroad[5] – preventative advice in this area underlines a big gap for me in my daily practice
- The CDC 'Yellow Book' for 2020 was launched at the conference and its lead editor, Gary Brunette gave a talk on the updates to the new edition.

What are the barriers to going?

Time and money! When travel is factored in, I find I'm away from my desk for four to five days, so there's lost income. In my role as a TMSI Executive Committee member, my conference registration fee (€600) was paid for by TMSI. All other expenses are covered by myself – flights, hotel accommodation and incidental expenses. I always opt to stay in the conference hotel, even if it's more expensive than an Air Bn'B alternative because I feel it allows me to maximise the amount of time I can spend on-site and increases the chances I'll attend more sessions. I minimise the costs by booking well in advance. If you know you're going to go, it makes sense to book everything six or seven months in advance, to avail of the lowest conference registration fee (this climbs closer to the conference day), the conference rate for the hotel and sometimes an airfare saving.

Did you have to fulfil any TMSI tasks while in Washington?

Yes. TMSI is member organisation of the Northern European Conference on Travel Medicine (NECTM). Like CISTM, the NECTM meeting is held every two years and the next NECTM conference will be in 2020 in Rotterdam. There was a NECTM Steering Group meeting held early on Saturday 8th June at the conference hotel, to capitalise on the fact that some of the member society leaders were in Washington, along with a member of the conference organising company, who were manning a NECTM promotional stand in the exhibition area of the CISTM meeting.

You're very focussed on the work side of the conference. Tell me you didn't go all the way to Washington and not do some tourism?

Interior, Smithsonian National Air and Space Museum (pic: Smithsonian)

The hotel was a seven-minute car drive from the White House and the National Mall, which runs from the Capitol Building all the way to the Lincoln Memorial, with the Washington Monument as its centrepiece. I had never been to the city. I love aviation and space and if you know anything about those subjects, you'll know that the Smithsonian National Air & Space Museum is located on the National Mall. I left the hotel at lunchtime on the Friday, got in a taxi outside and a lovely man from Puerto Rico, who's lived in Washington for years, took me on a drive past the White House, the Capitol Building, the Supreme Court and the Library of Congress, before dropping me off outside the Smithsonian. I went inside, got some goodies for my kids in the gift shop and then wandered around for an hour, looking at everything from a life-size Apollo Lunar Module to the plane that Charles Lindberg used to make the first crossing of the Atlantic. The taxi driver who took me back to the hotel was a senior citizen originally from Louisiana, straight out of central casting, with blues music playing on the radio. He took me by the Washington Memorial, the Lincoln and Jefferson Memorials and back to the hotel. We had a great chat. President Trump was due back in Washington that day, following his trip to Europe and I saw 'Marine One', the helicopter he travels in, flying overhead to the White House. I have no idea if he was on board! I liked Washington. I'd go back.

If I ask you whether TMSI members should bother going to the NECTM conference in Rotterdam in June next year, you're inevitably going to say 'yes'. Sell it to me!

You'll get almost as much academic value for about a quarter of what I paid to go to Washington and in a much more intimate setting! All you have to do is fly to Amsterdam, take a one-hour train ride from Amsterdam airport to Rotterdam Central station. The conference centre is across the road (I made the trip as part of a site visit in my role as a NECTM committee member in late 2018). There will be loads of accommodation options (inexpensive compared to Amsterdam) and you can tie in a holiday by train to nearby parts of Europe (like Brussels) at the same time. You'll meet lots of European colleagues and accumulate a lot of CPD credits in two or three days. Keep an eye on www.tmsi.ie for more details – we already have some information up on the site.

Simon Collins will deliver an OSKE at the next TMSI meeting in Athlone on 21st September on 'Highlights from the World Conference of Travel Medicine 2019'.

References:

1 Mother-to-child transmission of Chikungunya virus: A systematic review and meta-analysis. Contopoulos-Ioannidis D, Newman-Lindsay S, Chow C, LaBeaud AD. PLoS Negl Trop Dis. 2018 Jun 13;12(6):e0006510

2 Estimating the annual attack rate of seasonal influenza among unvaccinated individuals: A systematic review and meta-analysis. Somes MP, Turner RM, Dwyer LJ, Newall AT. Vaccine. 2018 May 31;36(23):3199-3207

3 Are probiotics and prebiotics effective in the prevention of travellers' diarrhea: A systematic review and meta-analysis. McFarland LV, Goh S. Travel Med Infect Dis. 2019 Jan - Feb;27:11-19

4 This point is re-iterated in the Measles chapter of the Immunisation Guidelines for Ireland https://www.hse.ie/eng/health/immunisation/hcpinfo/guidelines/

5 Data presented by Dr. Andrea Holmes (NUI Galway) at a presentation delivered by her at the conference and highlighted further in The Risk of Sexual Assault and Rape During International Travel: Implications for the Practice of Travel Medicine. Kennedy KM, Flaherty GT. J Travel Med. 2015 Jul-Aug;22(4):282-4

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TEST YOUR KNOWLEDGE – MULTIPLE CHOICES QUESTIONS IN TRAVEL MEDICINE:

By Dr. Joseph Sim.

(1) Respiratory Syncytial Virus:

[A] A common & highly infectious respiratory virus that usually causes severe life threatening infections across all age groups.

[B] Is NOT a notifiable disease monitored by HSE-HPSC.

[C] RSV can survive on surfaces / objects for up to 24hr.
Outbreaks typically occur in winter months particularly Dec & Jan.

[D] Immunity is incomplete and short-lived and repeat infections can occur.

(2) Disease surveillance:

[A] Health Protection Surveillance Centre (HPSC) is Ireland's specialist agency for surveillance of communicable diseases.

[B] HPSC provides independent advice and timely information and carries out disease surveillance, epidemiological investigations and related research / training and it is an essential communication point in forecasting and responding to disease outbreaks and incidences.

[C] Disease surveillance is an information-based activity involving the collection, analysis and interpretation of data followed by advice on appropriate treatments of diseases.

[D] For disease surveillance to be effective, the collection of surveillance data must be standardized, case definition must be clear and health facilities involved must be able to recognise the clinical manifestations of the reportable diseases.

(3) Hajj and Unmrah:

[A] Hajj takes place in the first month of the Islamic calendar; Umrah can be undertaken at any time of the year.

[B] Visitors from all countries arriving in Saudi for the purpose of Umrah or Hajj are required to submit a certificate of vaccination with the quadrivalent (ACYW135) vaccine issued no more than 3yr (polysaccharide vaccine) or 5yr (conjugate vaccine) and no less than 10 days before arrival in Saudi Arabia.

[C] Proof of polio vaccination is required for visitors from polio-endemic & re-established transmission countries and oral polio vaccine may be administered at border points.

[D] Efforts to prevent Middle Eastern Respiratory Syndrome Corona Virus (MERS-CoV) during Hajj and Umrah have been unsuccessful.

(4) Diabetes and travel:

[A] Diabetes related medical supplies, equipment and medications are allowed through airport checkpoints once prescription / doctors notes are available and the medications / equipment are declared and inspected at border control.

[B] High altitude and extremes of temperature may affect the functioning / accuracy or reliability of blood glucose meters.

[C] Diabetics travelling to hot climate may be more at risk of hypoglycaemic episodes as the heat makes the individual more sensitive to insulin.

[D] Travel sickness may mask or exacerbate the symptoms of hyperglycaemia or hypoglycaemia so the traveller may need to check his / her blood glucose more often.

(5) What country is this:

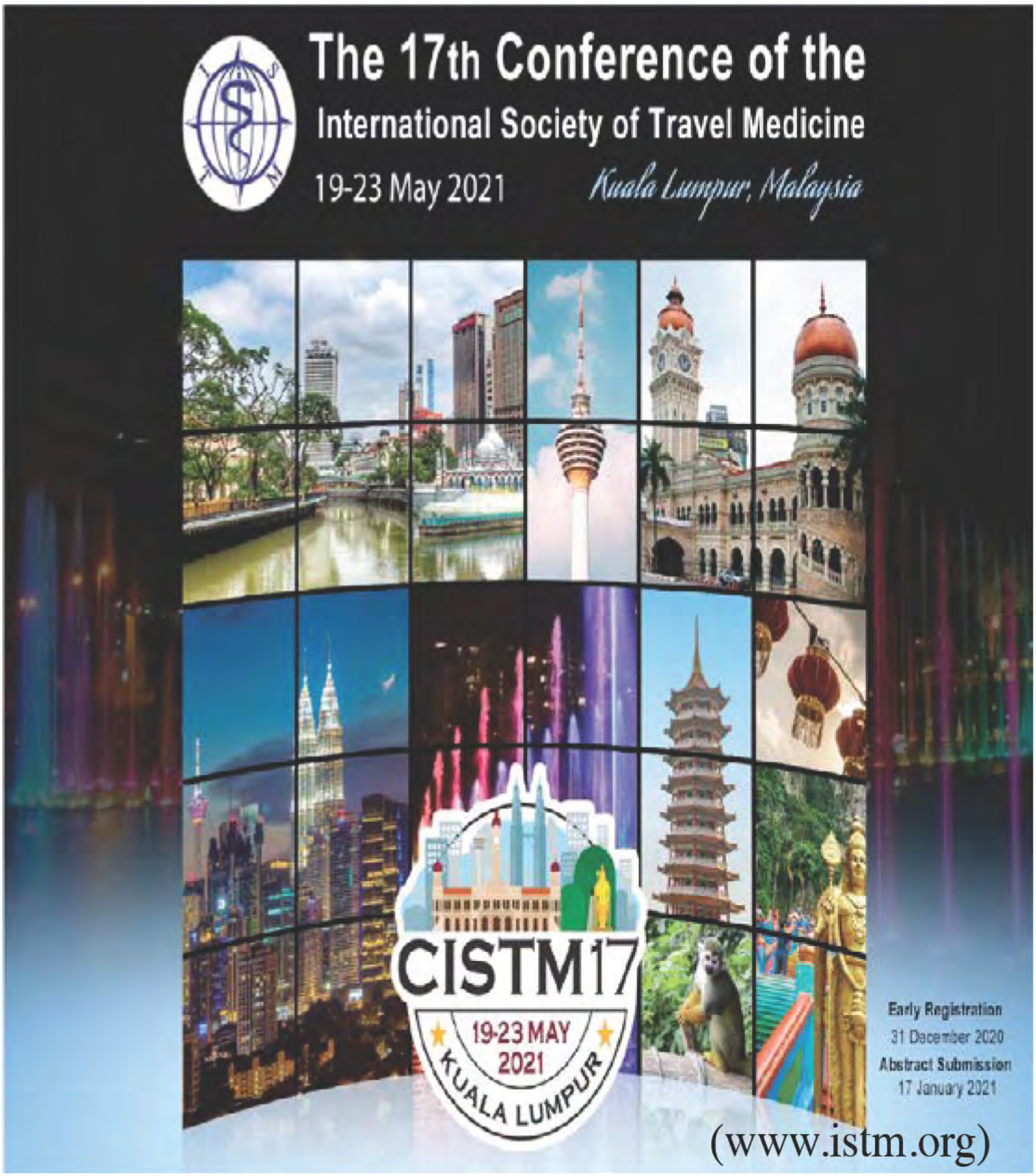
Hints:

[a] It is home to the Temple of the Sacred Tooth Relic – a Buddhist temple which houses the relic of the tooth of Buddha.

[b] This beautiful country's history was marred by past militant activities and a number of recent terrorist attacks led the Irish Department of Foreign Affairs and Trade to advise travellers on exercising a high degree of caution to this country.

[c] In Sept 2016, WHO certified this country to have eliminated malaria and malaria prophylaxis to this country is now not recommended.

Answers on page 9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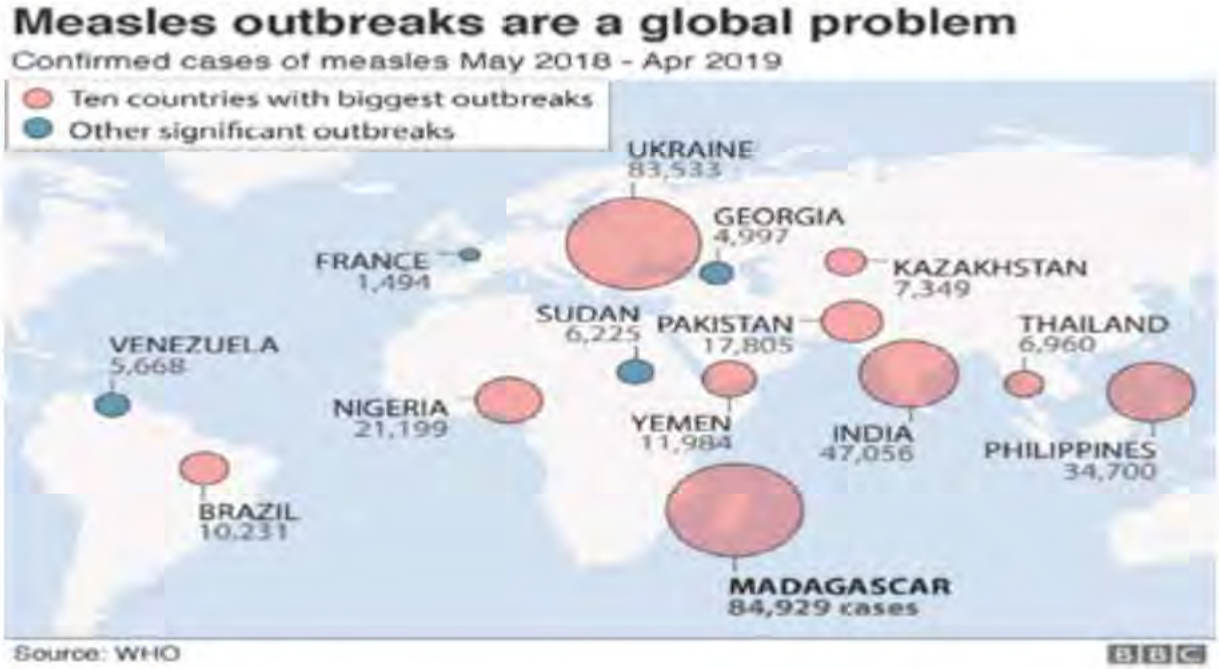
DON'T FORGET MEASLES AND MUMPS

Since the beginning of this year 53 cases of Measles and more than 1500 cases of Mumps have been reported in Ireland.

All age groups between 0 and 44 years of age have been affected by Measles. The age group most affected by Mumps were the 15-34 years old with more than 1200 cases alone.

Not only has Ireland been experiencing an upsurge of Measles cases, but also several European countries with the highest numbers being reported in France, Italy, Bulgaria, Lithuania and Poland and popular tropical holiday destinations like Thailand and the Philippines. Japan, the US and Taiwan are also severely affected.

The only effective prevention against Measles, Mumps and Rubella is the MMR vaccine...



Are our travellers at risk?

Those at highest risk include children (especially VFR) and those who will be living and/or working closely with the local population at their destination in countries with high endemicity or recent outbreaks.
The risk is also higher during summer months when people from different parts of the world come together at popular holiday destinations. Non-immune travellers may facilitate the spread of the disease to unvaccinated and susceptible populations, also on return to their home country.

To understand why our travellers might be at particular risk it is worthwhile to also look at the history of MMR vaccine in Ireland.

The Measles vaccine was introduced in Ireland in 1985 and MMR in 1988 with one dose given at 15/12. In 1992 a second dose was introduced for 12-13 years old adolescents. This schedule was changed in 1999 with the second dose being brought forward to age 4-5. Due to this change in schedule some children born in the 1990s missed one dose. A second gap happened beginning of the 2000s due to the 'Andrew Wakefield scare' with vaccination rates in the early 2000s dropping to 70%. In 2008 this rose again to 90% and a catch up campaign in 2012/14 was aiming to rise this figures further.

As a big group of our travellers are born between 1984 and 1999, they might have been affected by these gaps in vaccination, therefore, might have an incomplete vaccination status and be especially susceptible to Mumps and Measles.

A small study conducted in our clinic between 2015-2016, where we tested NGO workers for MMR immunity, revealed that 30% of patients born during or after 1975 lacked immunity against one of the three diseases. 18% of the patients tested were non-immune to Measles.

The Pre travel consultation is good opportunity to ask patients to check her/his vaccination history or if she/he recalls having had the disease and best obtain records of their vaccines. Patients born before 1978 most likely had Measles infection.

If there is no history of Measles infection or an incomplete/uncertain vaccination history, travellers should complete their course off MMR by either receiving one (if one certain/documented dose received in the past) or two doses of MMR vaccine (if no record of any MMR vaccine) separated by at least one month. If time is not sufficient to complete the two dose series prior to travel, one dose should be given, ideally two weeks prior to travel with the course being completed after the trip.

In children the first dose is usually given at 12 months of age, but can be administered from six months of age if the child is travelling to a country with a current outbreak/high endemicity.

As response to MMR vaccine below the age of one is suboptimal two further doses of MMR vaccine should be given after the age of 12 month.

Measles vaccine can be given with other vaccines recommended for travellers.

If both Yellow fever vaccine and MMR are required, ideally they should be given at least 4 weeks apart. If time before travel does not allow a four week gap, the vaccines may be given at any interval.

For further guidance also see Immunistaion guidelines Ireland, Chapter 12.

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1.) https://www.bbc.com/news/health-48512923
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3.) http://www.hpsc.ie/a-z/vaccinepreventable/measles/
4.) A.Weidenhammer & S.Collins: "Assurance of MMR immunity in Aid Worker Pre-Assignment Medical Exams - is Serological Verification Warranted?" Poster at CISTM 15, Barcelona

Dr. Astrid Weidenhammer

TEST YOUR KNOWLEDGE ANSWERS:

Questions/Sections	A	B	C	D
1 (Resp Syn Virus)	False	False	True	True
2 (Dis Surveillance)	True	True	False	True
3 (Hajj & Umrah)	False	True	True	False
4 (Rotavirus)	True	True	True	True
5 (What country)	Sri Lanka			

INTERNATIONAL TRAVEL HEALTH ADVICE FOR PATIENTS WITH HEART DISEASE

Introduction

The single greatest cause of death in adults globally is cardiovascular disease (CVD), and this phenomenon is also observed in the international traveller.[1] International travel can be a stressful experience especially for travellers with chronic medical conditions. Patients with heart disease should receive specific travel health advice which takes account of their chronic medical conditions and their intended travel-related activities.

While the Framingham study demonstrated that people who take vacations have a reduced risk of myocardial infarction (MI), certain aspects of the travel experience are likely to place heavier demands on the cardiovascular system. These include the stress of navigating airports, carrying heavy luggage, and dealing with queues, security checks, and unpredictable flight delays. Ten to forty percent of travellers report a fear of flying! Long-haul flights in the hypoxic environment of a commercial aircraft, disorientation and security concerns at the destination, combined with the effects of jet lag, all exact a toll on the traveller with heart disease. Travel to extremely cold climates may precipitate acute coronary syndromes[2], while excessive heat stress can lead to postural hypotension, especially in patients taking vasodilator antihypertensive agents and diuretics. It is interesting to observe that most MIs occurring during travel happen in the first 2 days of travel. Risk factors include driving by car, staying in tents or mobile homes, experiencing traffic jams and interpersonal conflicts with travelling companions.

Travel Insurance

Travellers with CVD should declare their medical histories to their travel insurance company and ensure that their policy covers medical care in the event of acute illness occurring during their planned activities abroad. Insurance policies should cover local medical costs as well as expensive medical evacuation or repatriation to another country or the patient's home country for definitive medical care.[3] Where possible, it is better to travel with a companion and to communicate one's medical history to this person. Copies of their medical summary, baseline electrocardiogram and prescriptions should be transported in hand luggage.

Fitness to fly/travel

Published recommendations are available to guide decisions about fitness to fly in patients with cardiovascular disease[4], cyanotic congenital heart disease[5], and heart failure[6] and the traveller may need additional assessments to determine their capacity to travel, including a treadmill exercise stress test or echocardiogram. In some cases, especially where the patient has had a recent hospital admission or a change in the dose of their cardiac medications, it may be better to postpone international travel until the condition has stabilised. As a rule of thumb, it is generally considered safe to fly 6 weeks after an episode of acute heart failure, 2 days after an uncomplicated elective angioplasty, 3 days after an acute coronary syndrome with a low risk patient and 10 days after an acute coronary syndrome in a patient at moderate risk. Patients at high risk after an acute coronary syndrome (based on ejection fraction and need for revascularisation) should defer travel. Travel to high altitude is contraindicated in travellers with unstable angina, or an MI in the previous 6 months. The patient should not travel by air within 2 weeks of successful drainage of a procedure-related pneumothorax.

Vaccinations and general health advise

The traveller with CVD should receive standard pre-travel health advice, tailored for the destinations involved, including food and water precautions, insect bite avoidance, and animal bite wound care in rabies endemic countries. Routine, recommended and required (e.g. yellow fever) travel vaccinations should be administered in the context of a travel health consultation. Additional vaccines to be considered in the CVD patient who is at greater risk of being hospitalised include influenza vaccine, pneumococcal vaccine, and hepatitis B vaccine. This is particularly important given that influenza is a recognised trigger for acute coronary syndromes. Where the traveller is taking warfarin as thromboprophylaxis, the international normalised ratio (INR) should be known before the administration of intramuscular vaccine injections but there is no threshold above which it has been reliably demonstrated that IM injections cannot safely be given.

Travelling hypertensive patients and patients with chronic heart failure should minimise salt intake in their diets

abroad. They should also avoid exposure to thermal extremes. Travel to high altitude presents particular risks for decompensation of heart failure or precipitation of angina symptoms[9], and the patient should be counselled on these risks. Travel for some people can be sedentary and all cardiac patients should continue to engage in moderate intensity physical activity but avoid unaccustomed exertion and a frantic travel itinerary. Alcohol intake should be moderate, and strict food and water safety advice should be followed throughout the trip to avoid travellers' diarrhoea.

Malaria prohpylaxis and drug-drug interactions

A comprehensive risk assessment of the traveller's likely exposure to mosquito bites in malaria endemic areas should be performed. Where malaria chemoprophylaxis is indicated, mefloquine should be avoided in patients with heart disease, and atovaquone-proguanil or doxycycline used instead. Written guidance should be provided on how to take the medication as well as the steps to take in the event of a fever upon return from their travels. Drug-drug interactions between anti-malarial medication and cardiac medications should be discussed with the patient's cardiologist. One that occasionally arises is the use of acetazolamide for prevention of high altitude illness. This increases the risk of aspirin toxicity so it should be avoided in CVD patients taking aspirin.

Pre-flight arrangements and precautions during flight

The traveller with CVD should discuss the need for in-flight supplemental oxygen with their general practitioner and with the airline company at least 2 weeks in advance of travel. They should also request wheelchair assistance at airports if the transfer demands from the check-in desks to their gate exceed their maximum exercise tolerance. A letter from their general practitioner may be required to obtain supplemental oxygen or extra assistance, and this letter should also be presented at the airport security station. It is important to keep well hydrated during the flight and to avoid caffeinated or alcoholic beverages. The traveller should be encouraged to walk frequently down the cabin aisle, in order to reduce the risk of travellers' venous thrombosis. Where there is no evidence of peripheral arterial disease, it is reasonable for the traveller with heart disease to wear below knee compression flight socks for the duration of their journey although a recent debate held at the CISTM16 conference has cast doubt over the evidence base for this recommendation.

Cardiac devices

Implanted cardiac devices such as permanent pacemakers and cardioverter-defibrillators facilitate travel for many patients with heart disease. Difficulties at airport screening may be avoided by declaring the presence of the device, and providing the screening personnel with a device card and physician letter. The manufacturer's card should display the device brand and identification number. The security officer may perform a pat-down search instead and avoid passing over the device with a hand-held security wand[5]. The traveller should have access to manufacturer contact information during travel in case of apparent device malfunction. Air travel does not affect the pacing threshold of pacemakers which are well shielded from the effects of electromagnetic and cosmic radiation.

Transporting medications

All medications should be transported in their original pharmacy-labelled containers and in double the quantities required for the trip. Medications must not be packed in the luggage hold during the flight. The use of sedative-hypnotics should be strongly discouraged as they will impair passenger mobilisation during the flight. Medications should be taken at the destination local time to avoid confusion. For long-term or expatriate travellers, prior contact should be made with a local physician or pharmacist to ensure that an equivalent drug is available in the host country. Some medications may degrade with exposure to sunlight so all drugs should be stored in a cool, dry place. With disruption of one's normal daily routine, patient medication adherence may be compromised, and the traveller should use day-labelled blister packs to ensure adherence.

Patients on Warfarin

Warfarin anticoagulation during longer trips will require access to a reliable INR monitoring clinic or calibrated point of care device. Where the INR is unstable prior to prolonged travel, it may be possible to convert the patient to a novel oral anticoagulant to avoid the need for monitoring.[7] The anticoagulated patient should be careful not to markedly increase the amount of dietary vitamin K to avoid the risk of developing a sub-therapeutic INR.[8] The risk of dangerous bleeding from traumatic physical injury should be borne in mind when considering adventure pursuits where falls are a risk. Antibiotics used for self-management of severe travellers' diarrhoea such as azithromycin may

potentiate the effect of warfarin by a factor of 3-5. Proguanil may exert a similar effect so caution is advised.

Accessing Healthcare abroad

Healthcare resources in many popular tourist destinations in developing countries are inferior to the traveller's domestic medical care, and the ill traveller may find it difficult to access appropriate medical care in an emergency, especially in a remote wilderness setting. A MedicAlert® bracelet may be critically important in the event of a sudden collapse in an unfamiliar environment. The CVD traveller and travelling companion should be familiar with how to summon emergency medical care and should carry a list of local English-speaking physicians.[11]

Unwell on return

Febrile illness, rash, diarrhoea, and eosinophilia are the most common clinical presentations of disease in the returned traveller. The failure to obtain a travel history in an ill returned traveller can lead to potentially fatal diagnostic delay where a traveller has developed a tropical infectious disease.[12] The intending traveller should be advised to seek immediate medical help in the event of a fever occurring up to 6 months after returning from a malaria area. Travel to tropical regions may itself rarely cause heart disease, including Lyme myocarditis or heart block, and Chagas disease, the latter of which may present to a general practitioner with shortness of breath secondary to dilated cardiomyopathy.[13]

The majority of patients with heart disease will find their travels rewarding and beneficial to their health and wellbeing. Patients should be encouraged to travel with due attention to travel health risks and precautions. Close cooperation between the travelling patient, the general practitioner, and cardiologist will help to promote safe and healthy international travel. We are currently analysing the results of a qualitative study which used semi-structured interviews to gauge the experiences and perceived risks of a group of patients with various categories of cardiovascular disease.

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Prof. Gerard Flaherty

NECTM8
1ST ANNOUNCEMENT

Liverpool School of Tropical Medicine (LSTM)

Hi all, I'm a GP with an interest in Tropical Medicine. From February to May this year I attended the Liverpool School of Tropical Medicine (LSTM) to undertake the Diploma in Tropical Medicine and Hygiene (DTM&H). LSTM established the Diploma in Tropical Medicine in 1904 and was the first institute in the world devoted to the study of medicine and health in the tropics. The contributors to the course are very active in research and often are leaders in determining the response to existing, emerging & neglected tropical diseases.

It is a 13 week full time course and aims to provide physicians with key knowledge of tropical medicine in a relatively short amount of time.

There were 74 participants in my group from a diversity of specialties including e.g. GPs, Military doctors, Infectious Diseases/HIV specialists, Paediatricians, NCHDs and Microbiologists. Students came from all over the world: Nigeria, Sierra Leone, Sri Lanka, Malaysia, Hong Kong, Taiwan, Norway, The Philippines, Myanmar, Malta, India, Spain, Italy, Canada, Ireland, UK NZ & Australia to name a few! Some had worked in developing countries prior to attending but the majority had not.

participants in my group

The course is very much orientated towards equipping medics to work in a developing country with generally limited resources. Its aim was also to make us think about the more complex cultural socio-economic & technical challenges associated with being involved in healthcare provision in such a setting. I do feel that this is also a hugely valuable course for those of us seeing patients returning from tropical destinations whether in the Emergency Department, the GP surgery, hospital or in a travel clinic. We have an increasing migrant population and are frequently attended by unwell patients on their return from overseas travel.

It's a paper free course with access to a virtual learning environment 'Brightspace' which provided a calendar and suggested reading. This allowed you to download lectures once uploaded by the relevant presenter. It could be a little tricky to navigate at times and you did need to keep an eye on it as new material was continuously uploaded.

In the first week the course started at quite a relaxed pace, however that quickly changed to a pretty intense timetable. Time really does fly and exam fever and stress levels ramped up quite dramatically in the last 4-5 weeks.

Local tour

Each week tended to be broken down into lectures, laboratory work, clinical scenarios and group work based on major topics e.g., Malaria, HIV, TB, child & maternal health. There was a large emphasis on Public Health throughout. Microscopy was taught in the Dagnall Laboratory excellently ran by Ms Maria Midgley & her team where we were presented with thick & thin films and prepared faecal slides for egg & cyst recognition.

The incredibly enthusiastic lecturers ranged from an 89 year old Sir Eldryd Parry (who has received a lifetime achievement award for his work in tropical medicine), to engineers involved with the logistics of setting up refugee camps. Standouts contributors for me were Dr Angela Obasi one of the course coordinators and Dr James LaCourse who gave a number of entertaining lectures on soil transmitted helminths all while wearing a stool emoji hat. I salute his total commitment to his topic.

I would advise participants to start studying early on. It gives a better chance to try and distil down the huge amounts of material covered. Many used tools such as ANKI flashcards or mind maps to aid study. There was a real spirit of cooperation on the course e.g. those who had a good working knowledge of statistics were more than willing to try and break it down for those of us for whom medical statistics is akin to having a tooth pulled.

LSTM houses the largest and most diverse collection of tropical venomous snakes in the UK and one of the major highlights was the snake tour where we saw some of the snakes being milked for their venom.

Graduates with the DTM&H are highly sought after by MSF & other NGO agencies. There was an NGO evening during the course where organisations came to give presentations & provide information for potential recruits. During the course there were many potential opportunities discussed for those interested in research positions and working overseas.

At the beginning of the course a WhatsApp group was set up which was invaluable in not only keeping everyone up to date with course information but also helped coordinate a healthy social calendar. Among ourselves we enjoyed film nights, trips to Snowdonia, weekly netball & 5-aside football, rock climbing group and quiz and culture nights out.

Liverpool is an incredibly friendly city. In the first week one of the Liverpool natives on the course led his own guided walking tour of Liverpool which was great craic and really informative!

There's loads to do in Liverpool with the Cavern club, the Royal Liver building, the Albert Docks, the bombed out church, Baltic market, Anfield (football is sacrosanct there), Tate and maritime museums and more Irish pubs than Temple Bar (probably). Expect to get plenty of visitors from home.
Anyone who is considering the course and wishes to ask me any further questions please feel free to email me at mary.durcan@tmb.ie

Dr. Mary Durcan

Dr. Mary Durcan received an Educational Bursary from TMSI for this course.

For further details and application for this Education Bursary Scheme please see Notice Board on page 17.

TRAVEL MEDICINE ROADSHOW

Jane Chiodini, the current dean of the faculty of Travel Medicine in Glasgow is currently running a ‚Travel Medicine Roadshow' in several locations in the UK including Northern Ireland.

It is a half day meeting covering a selection of topics, which aim to provide updated health advice relevant to our day to day practice as well to understand the value and importance of keeping up to date in the practice of travel health.

I went to the ‚Roadshow' which was held in April in Glasgow.

It was attended by health care professionals from various backgrounds and with different levels of experience in Travel Medicine.

Within the half day Jane and her husband Peter Chiodini, together with two other very good speakers Dr Fiona Steven (GP and FTM board Member) and Amy Gannon (Travel Health Nurse) covered important updates in Malaria guidance, Rabies Pre and Post Exposure Prophylaxis/Treatment, Yellow fever challenges and changes to vaccine and disease guidance.

The atmosphere was very pleasant and there was plenty of room to ask questions or discuss tricky cases during a coffee break.

As the next Roadshow will be held in Belfast on 10th September - literally up the road - it is a great opportunity for anybody who is interested in getting some general updates in Travel Medicine (outside of TMSI) and discuss current day to day issues and challenges with our very high profile colleagues from the UK.

Further information please see below.

Dr. Astrid Weidenhammer

Jane Chiodini, Dean of the Faculty of Travel Medicine at the Royal College of Physicians and Surgeons of Glasgow brings you an essential update on the fast moving field of travel health.

Each of the six half day events will provide delegates with an update on many topics, including vaccines, malaria, professional issues and the very latest developments in travel. It will also give an opportunity for networking with other health care professionals.

Who should attend?
All health care professionals practising travel medicine

To find out more and register, contact
hanne.wylie@rcpsg.ac.uk

rcp.sg/tmroadshow

24 April - Glasgow
Royal College of Physicians and Surgeons of Glasgow, 232-242 St. Vincent Street, Glasgow G2 5RJ

14 May - Manchester
The Nowgen Centre, 29 Grafton Street, Manchester M13 9WU

22 May - Newcastle
International Centre for Life, Biomedicine West Building, Times Square, Newcastle NE1 4EP

12 June - Birmingham
Birmingham Repertory Theatre, Broad Street, Birmingham B1 2EP

28 June - Southampton
Solent Conference Centre, The Spark, Southampton Solent University, East Park Terrace, Southampton SO14 0YN

10 September - Belfast
The MAC Belfast, Metropolitan Arts Centre, 10 Exchange Street West, Belfast BT1 2NJ

Fees
Member: £50 / Non Member: £90

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
TRAVEL MEDICINE

NOTICE BOARD

Travel Medicine Society of Ireland Educational Bursary Scheme

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

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

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

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

For further details and application form please contact Anne Redmond at anne.redmond@tmsi.ie
Closing date for receipt of 2020 applications is: **31st December 2019**

Gerard Flaherty, Past President of TMSI, has been appointed as Co-Chair of the Scientific Programme Committee for the 17th CISTM conference to be held in Kuala Lumpur, Malaysia, in May 2021. He will also represent the TMSI on the scientific programme for the 8th NECTM conference in Rotterdam, the Netherlands in June 2020.