TAISTEAL

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NEWSLETTER

ed. S. Collins

WHAT TO DO WITH A PATIENT REQUESTING YELLOW FEVER VACCINATION WHO REPORTS AN EGG ALLERGY ???

(The pictures are of a patient in my practice last month and are used with her permission).

Picture 1: 0.45mm x 10mm needle

As an egg allergy is a contraindication to Yellow fever vaccination the simple answer would be do not give it and where appropriate issue a yellow fever exemption certificate. There are however options and one is that a yellow fever test dose can be given .

Who is suitable ? If the patient gives a history of an anaphylactic reaction to egg then that is a definite contraction, but if the reaction was mild including rash and even vomiting it is still possible to give a test dose .

After taking a complete history, possibly giving the patient an oral antihistamine and ensuring they are making a fully informed written consent, the doctor may prescribe the test dose. This may be administered by the doctor or nurse .

Method

- Reconstitute the vaccine as usual but draw up 0.1ml and administer it intradermaly (as in picture)

Picture 2: 0.1 ml vaccine administered ID

- Then observe if there is no local reaction after 10 minutes. If no reaction has occurred, the physician can reassess the patient and make the decision as to whether they are happy to administer the remaining vaccine and issue the yellow fever vaccination cert.

Picture 3: almost immediate local red skin reaction

- If however there is localized reaction then no further vaccine is given .

Picture 4: reaction spreads over a larger area 10 minutes after administration

Picture 5: 15 minutes post administration

- At a later stage, Yellow Fever antibody titre could be measured to see if there has been adequate response to the reduced dose (I have done this for another patient and the antibody level has been positive).

The following press release from the WHO details recent findings on the use of reduced dose of the vaccine and makes for an interesting read:

"**Date:** 17 June 2016 12:09 Subject: Lower doses of yellow fever vaccine could be used in emergencies

Lower doses of yellow fever vaccine could be used in emergencies

GENEVA - 17 June 2016: The yellow fever vaccine given as one fifth of the regular dose could be used to control an outbreak in case of vaccine shortages. Experts agreed with this proposal at a meeting convened by the World Health Organization (WHO) to consider potential shortages in yellow fever vaccine due to the outbreak in Angola and Democratic Republic of Congo. WHO Strategic Advisory Group of Experts (SAGE) on Immunization reviewed existing evidence that demonstrates that using a fifth of a standard vaccine dose would still provide protection against the disease for at least 12 months and possibly much longer.

This approach, known as fractional dosing, is under consideration as a short-term measure, in the context of a potential vaccine shortage for use in emergencies. This approach is not proposed for routine immunization, as there is not yet enough data available to show that lower doses would confer the life-long protection provided by a vaccination with one full dose.

"Yellow fever outbreaks in Angola, Democratic Republic of the Congo and Uganda are placing unprecedented demands on vaccine supply for emergency vaccination campaigns to control the spread of the disease," says Jon Abramson, chair of the WHO Strategic Advisory Group of Experts (SAGE) on Immunization. "Right now we have enough vaccines in the global stockpile to cope with the ongoing outbreaks if there are no further extensions. However, given the wide spread of the disease in Angola and the potential for it to get out of control in the city of Kinshasa, in the Democratic Republic of Congo, WHO and partners are seriously considering the use of this dose-sparing strategy to prevent transmission through large-scale vaccination campaigns."

At the request of the Emergency Committee regarding yellow fever convened by WHO's Director-General on 19 May, the WHO secretariat has been exploring options, based on existing evidence, on ways to increase vaccine supply in case of urgent need. SAGE was asked to review the evidence and options presented by WHO. A formal evaluation and recommendations by SAGE on the use of lower doses of yellow fevervaccine are planned for October 2016. In the interim, SAGE found that the available evidence is sufficient to determine that fractional dosing of yellow fever vaccine to one fifth of the standard dose (0.1ml instead of 0.5ml) could be a safe and effective option for mass vaccination campaigns to control urban outbreaks in situations of acute vaccine shortage.

More research is needed to find out whether fractional doses would be effective in young children, who may have a weaker immune response to yellow fever vaccine.
Practical issues on administering the reduced doses need further investigation, including obtaining the necessary supply of suitable syringes.

International Health Regulations require full dose for travellers Yellow fever is the only disease specified in the International Health Regulations (IHR) for which countries may require proof of vaccination from travellers as a condition of entry. The IHR were amended in 2014 to indicate that a single dose of the vaccine is sufficient for life-long immunity and therefore extends the validity of vaccination certificates to the life of the person vaccinated. All countries must abide by this new amendment when it enters into force on 11 July 2016. A yellow fever vaccine given at a fractional dose would not qualify for a yellow fever certificate under the IHR requirements. Travellers will need to obtain the full dose of the vaccine to be eligible for the yellow fever certificate.

Global supply WHO has prequalified yellow fever vaccines from 4 different vaccine manufacturers which together produce an annual volume of around 80-90 million doses. Prequalification means that vaccines and medicines meet WHO's high standards of quality, safety and efficacy. The global stockpile, funded by Gavi, the Vaccine Alliance, has 6 million doses for emergency use per year and this has already been depleted twice since February of this year. To date, WHO and partners have sent around 18 million vaccine doses to Angola, Democratic Republic of the Congo and Uganda for emergency use to control the current outbreaks. In addition to fractional dosing, WHO's SAGE group is looking at ways to prevent yellow fever outbreaks on a long-term basis by strengthening mass vaccination catch-up campaigns in conjunction with improving routine childhood immunization in countries with yellow fever. WHO's response strategy to the ongoing outbreaks requires coordinated work with partners in five areas: surveillance and risk assessment, vaccination, case management, social mobilization and risk communication and vector control."

Siobhan Grehan
Director of Nursing
Tropical Medical Bureau

DISCONTINUATION OF LARIAM IN IRELAND.

On the 24th June, 2016, Roche Products Ireland Ltd announced the discontinuation of Lariam from the Irish Market, citing global fall in sales.
Lariam, (generic name Mefloquine) first obtained a licence in Ireland in 1989 but was available in other jurisdictions since 1985. Since then it has proven to be a useful tool in prevention and treatment of Malaria. Many travellers found the weekly regimen to be easy and convenient and conducive to good adherence. The drug is particularly effective against falciparum Malaria but resistance emerged in South East to the extent of making it ineffective there.
Reports of neuropsychiatric side-effects emerged early, including several well publicised court cases here and abroad. This led the company to issue a precautionary notice in July 2013, in the form of a direct communication to health care professionals. The manufacturer has warned that the drug may induce potentially serious neuropsychiatric disorders, including psychosis, hallucinations, suicidal thoughts and suicide. Prescribers are expected to exercise caution by careful history taking and issue written and verbal warnings.
Cardiac side-effects also became apparent in the form of QT interval prolongation. Again deaths have been reported. As Lariam has a long half life, a wash out period of 15 weeks is required to avoid drug interactions. Halofantrine and ketoconazole are particularly singled out for mention for cardiac side-effects while on Lariam or soon after discontinuation.

Lariam lowers the threshold for epileptic type seizures and is contraindicated in known epileptics or persons taking anti seizure medication or other neurotrophic drugs such as antidepressants and SSRIs. Provoking a seizure can have long-term consequences to the user for driving and operating machinery and is to be avoided.

The drug has received a lot of adverse publicity recently in Ireland. It was prescribed to Irish soldiers serving in Chad in 2009. Many reported side-effects including neuropsychiatric symptoms. A government report into the matter was received by then minister Alan Shatter but has not been made public. The US Army ceased prescribing Lariam to soldiers serving overseas in 2009. In retrospect, it would seem logical to avoid a drug, known to cause paranoia, anxiety and hallucinations when you are in a war zone and carrying a weapon.

Mefloquine is an extremely useful drug across all ages. The majority of users report no upsetting side-effects however in one study, up to 17 % of people stopped taking it due to side-effects which they considered too uncomfortable to continue (3). It is considered safe in pregnancy, with no reports of side-effects over expected (4). It is cost-effective as long as one stays outside of clearly defined areas of resistance at Thai borders. Lariam does have generic alternatives but none are licensed in Ireland. A generic is available in the UK and many other parts of Europe. Lariam and generics remain licensed in Spain, Portugal and Greece and countries outside of Europe where it is used regularly for the treatment of Malaria. Here in Ireland, it is used mostly for traveller prophylaxis and standby treatment while abroad. We only have a few dozen reported cases of Malaria each year and they are all imported. Maintaining a licence for a drug used to treat 50 to 80 cases per annum might not seem commercially viable. Anecdotally, Atovaquone/Proguanil (Malarone) has overtaken Mefloquine in traveller Malaria prevention. The advent of generic Malarone has brought a reduction in price with inevitable increase in market share.

Lariam/Mefloquine is on the WHO's list of essential medicines. It's loss will cause concerns to health authorities here who maintain stocks for emergency use. Existing supplies are expected to run out within six months, but it should be available thereafter on a named patient basis. We have seen regular vaccine shortages in recent years; Travel Medicine is becoming more about counselling and advice and less about prescribing. It remains to be seen if the loss of Lariam for travellers seeking prophylaxis leads to an increase in Malaria in returned travellers, who now have fewer options for treatment.

Ref:

1. Kim Kirwan, 24 Jun 2016, Regulatory affairs manager, Roche, Communications to Healthcare professionals.
2. Martia Luz Amador, 01 Jul 2013 Communication to healthcare professionals.
3. Schlagenhauf P., "The Position of Mefloquine as a 21st Century Malaria Chemoprophylaxis". Malaria Journal 2010, 9:357
4. Schlagenhauf P., "Pregnancy and Foetal Outcomes after exposure to Mefloquine", 2012, Clinical Inf Diseases.
5. National print and screen media.

Dr. Conor Maguire

DISCONTINUATION OF LARIAM – WHERE TO NOW?

On the 24th June Roche Products (Ireland) Ltd announced that following " a routine portfolio assessment", they had taken the decision to discontinue Lariam effective from 31st July 2016. Stocks are expected to last until the end of August 2016.

Many if not all of us were using Lariam as prophylaxis for children entering malarial risk areas. So what are our options now?

1. Doxycycline can be used for children over 12 years. This is available on the GMS for those with medical cards.
2. For those children under 12 years, Malarone Paediatric is the only option once Lariam becomes unavailable. It is unlicensed but can be ordered via your pharmacy. However it is **NOT** available on the GMS in Ireland. It costs approximately €27 on a private prescription for a box of 12.

   It is used for children between 11kg and 40kg. Dosage is 1 tablet daily for those between 11kg and 20kg, 2 tablets daily for those between 21kg and 30kg, and 3 tablets daily for those between 30kg and 40kg. Over 40kg, the adult dosing can be used (and is available on the GMS). It cannot be used for children under 11kg.

   For an average 2 week holiday the cost will therefore range from approximately €50 for the lowest dose of 1 tablet daily, but rising up to €150 for a child between 30kg and 40kg.
   For further information, see https://www.medicines.org.uk/emc/medicine/9745

Many of our patients bringing their children on holidays to malarial risk areas are of African origin who are VFR – visiting friends and relatives. Cost is a significant factor in their travel and most of us will have had some difficulties in encouraging vaccination for them and their children. Malaria is probably the most serious risk to which they will be exposed in their travel; they are all aware of this and are keen to take their malaria prophylaxis. Most however have medical cards and therefore to date cost has not been an issue. We will therefore have to anticipate and try to deal with the new difficulty we will now encounter in prescription of malaria prophylaxis for children. It is to be sincerely hoped that this decision by Roche does not result in children failing to be adequately protected from malaria when entering high risk areas.

Dr. Marie Scully
Abbey House Medical Centre, Navan

EDITORIAL: RECURRING ISSUES AROUND YELLOW FEVER VACCINATION

No other vaccine focusses the mind as much that for Yellow Fever. In this edition of Taisteal, the vaccine makes an appearance in three different forms. Conor Maguire has written about a historic change to the validity of Yellow Fever vaccination certificates (YFVCs)[1] . Elsewhere, Siobhan Grehan has an important piece on how conduct a suitability test on a patient requiring vaccination for Yellow Fever who feels they may have an egg allergy.

Now and again a surprising e-mail will arrive in my inbox from a patient who is abroad, part-way through their travels. In early June I received one such communication from a patient I had seen early in 2016, prior to her planned overland trip from South Africa to Tanzania. I had reassured her that Yellow Fever (YF) vaccination was unnecessary, both from immigration and protection points-of-view. YFVCs are supposed to be required for entry to Tanzania only if the traveller is arriving from an infected country or if the traveller has spent more than 12 hours in the airport of an infected country while en route to Tanzania. My patient's e-mail to me came from just inside southern Tanzania, having entered the country from northern Malawi (a YF-free country). Not only had she been asked to present a YFVC in order to be allowed entry to Tanzania, but her failure to be able to do so had led to her being vaccinated by the Tanzanians at the border crossing! Attached to her e-mail were photos of a correctly completed YFVC bearing a Tanzanian Ministry of Health stamp. A second photo showed an official receipt, complete with a holographic anti-counterfeit marking on it. It seemed not to matter that the Tanzanian government has signed a WHO agreement saying that YFVCs are unnecessary for those arriving from non-YF countries.

Within a couple of weeks of this episode, a paper referred to by its authors as the first to investigate YFVC checks in Tanzania or any other country appeared online (and is also referred to by Gerard Flaherty elsewhere in this issue in his journal round-up article); Schönenberger and colleagues[2] provide a fascinating insight into the disparity between internationally-accepted rules and the variability of their application in practice. The researchers surveyed 421 travellers to Tanzania who had attended a travel clinic in Switzerland between January and November 2015. 28% had YFVCs checked – some possessed them, some had Yellow Fever exemption certificates (YFEC) and some had neither. Those who possessed either a YFVC or a YFEC were permitted entry. Some of those possessing neither were subjected to vaccination. The authors recommend that travellers to Tranzania be given either a YFVC or YFEC pre-travel, until Tanzanian immigration officials correctly apply the WHO rule to which their government is a signatory.

Ref:

http://www.who.int/ith/annex7-ihr.pdf?ua=1
http://jtm.oxfordjournals.org/content/23/5/taw035

Dr. Simon Collins

BLOOD TRANSFUSIONS AND TRAVEL MEDICINE – FREQUENTLY ASKED QUESTIONS

I visited lowland areas of Kenya 6 months ago with my family. Can I donate blood today?

No. If you have visited a malarial area, you will be deferred from donating blood for 12 months.

I spent two weeks in tropical Brazil last year but we didn't visit the Amazon jungle. Will my blood donation be accepted?

Yes. Deferral from blood donations after visiting a non-malarial tropical area is for 3 months only.

I just returned from an area in the USA which is reporting cases of West Nile Virus infection. Will I be able to donate blood in Ireland?

As and from 30 August 2013, all donated blood in Ireland is screened for the presence of West Nile Virus, so travel to an area with the disease is no longer a barrier to giving blood.

I am a regular blood donor. I recently received travel vaccines for an upcoming trip to South East Asia. Is it true that I might be prohibited from donating blood in the future?

There are clear guidelines on when it is safe to donate blood after having received a travel vaccine:

Cholera – 48 hours if well

Hepatitis A – 48 hours if well and no intervening exposure to hepatitis A virus

Hepatitis B – 4 weeks, but 6 months if vaccine was received post-exposure

Influenza – 48 hours if well

Japanese encephalitis – 48 hours if well

Meningococcal disease – 48 hours if well

Polio (oral) – 8 weeks

Rabies – 48 hours, but 1 year if post exposure to animal bites in rabies endemic area

Tetanus/Diphtheria/Polio – 48 hours if well

Tick-borne encephalitis – 48 hours if well, but 1 year if post-exposure

Typhoid (injectable) – 48 hours if well

Yellow fever - 8 weeks

Source: https://www.giveblood.ie/Become_a_Donor/Give_Blood/FAQs/
Please check the Irish Blood Transfusion Service website for updates and for any changes to these restrictions.

Dr. Gerard Flaherty

" LA VIE ENTIRE DU SUJET VACCINÉ"

"The life of the person vaccinated". This is now the expiry dates of all Yellow fever certificates of Vaccination. In May 2014, the WHO's Strategic Advisory Group of Experts on immunization agreed that a single dose of yellow fever vaccine confers life-long protection. This was based on studies which revealed that since the introduction of the vaccine over sixty years ago, the number of people falling sick from yellow fever more than ten years after vaccination was negligible. In other words, if you have a record of a reliable vaccine having been given, there is absolutely no evidence that it ceases working after ten years. Other vaccines such as Hepatitis B, Rabies and Tetanus have also been proven to confer life-long immunity. Antibodies titres do not need to be checked, as the antibody response can be relied on to rise immediately following exposure.

The World Health Organisation amended the international health regulations in 2005. Article 7 came into force on July 11th this year. The amended regulations now state that "the period of validity of the related international certificate of vaccination against yellow fever, and the protection provided by vaccination against yellow fever infection under the IHR (2005), changed from ten years to the life of the person (traveller) vaccinated."

How does this affect travellers entering and leaving a Yellow Fever risk area? Each individual country, member state of the WHO is entitled to impose their own health regulations on their population; however they may not impose a condition that requires revaccination or a booster vaccine to be given as a condition of entry. This applies to all vaccination certificates, even certificates over ten years old with an expired validity date.

- Certificates of any age are valid for entry.
- There is no need to revaccinate or give a booster.

New certificates from now on should state the certificate is valid from ten days after the date of administration and the certificate expires on: "the life of the person vaccinated"

Ref: http://www.who.int/ith/annex7-ihr.pdf?ua=1

Dr. Conor Maguire

Items for the newsletter can be forwarded to:

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ADVISING INTERNATIONAL TRAVELLERS ABOUT HOTEL FIRE SAFETY

How often do we raise the issue of hotel fire safety precautions for hotel bedroom guests during travel health consultations? Probably not very often if we are honest! Whether we include essential safety information in a written handout to our travellers or address it as part of our verbal pre-travel health advice, we have a responsibility to alert our travellers to this risk. I recently wrote an article on the subject with a Chief Fire Safety Officer for the journal Travel Medicine and Infectious Disease.

The summary advice below is adapted from this publication: G Flaherty, M Hession, C Cuggy. Hotel fire safety for international travellers. Travel Medicine and Infectious Disease 2016; http://dx.doi.org/10.1016/j.tmaid.2016.05.011.

Reducing fire risk before a fire occurs:

- Ensure that the hotel meets fire safety specifications (perhaps an email to the hotel before you book)
- Book a room on the lowest floor possible (difficult to reach above the 6th floor in most hotels with a fire ladder)
- Consider bringing a smoke alarm (with fresh batteries) when travelling
- Enquire at the front desk about what the fire alarm sounds like and if there are any scheduled fire drills
- Review the emergency escape plan posted on the back of the bedroom door
- Locate fire exits on your level and count the number of doors between your room and the nearest exit on your level
- Check that the fire exits on your floor are not locked or obstructed
- Carry a flashlight in the event of a fire occurring at night

If escape from the bedroom is possible:

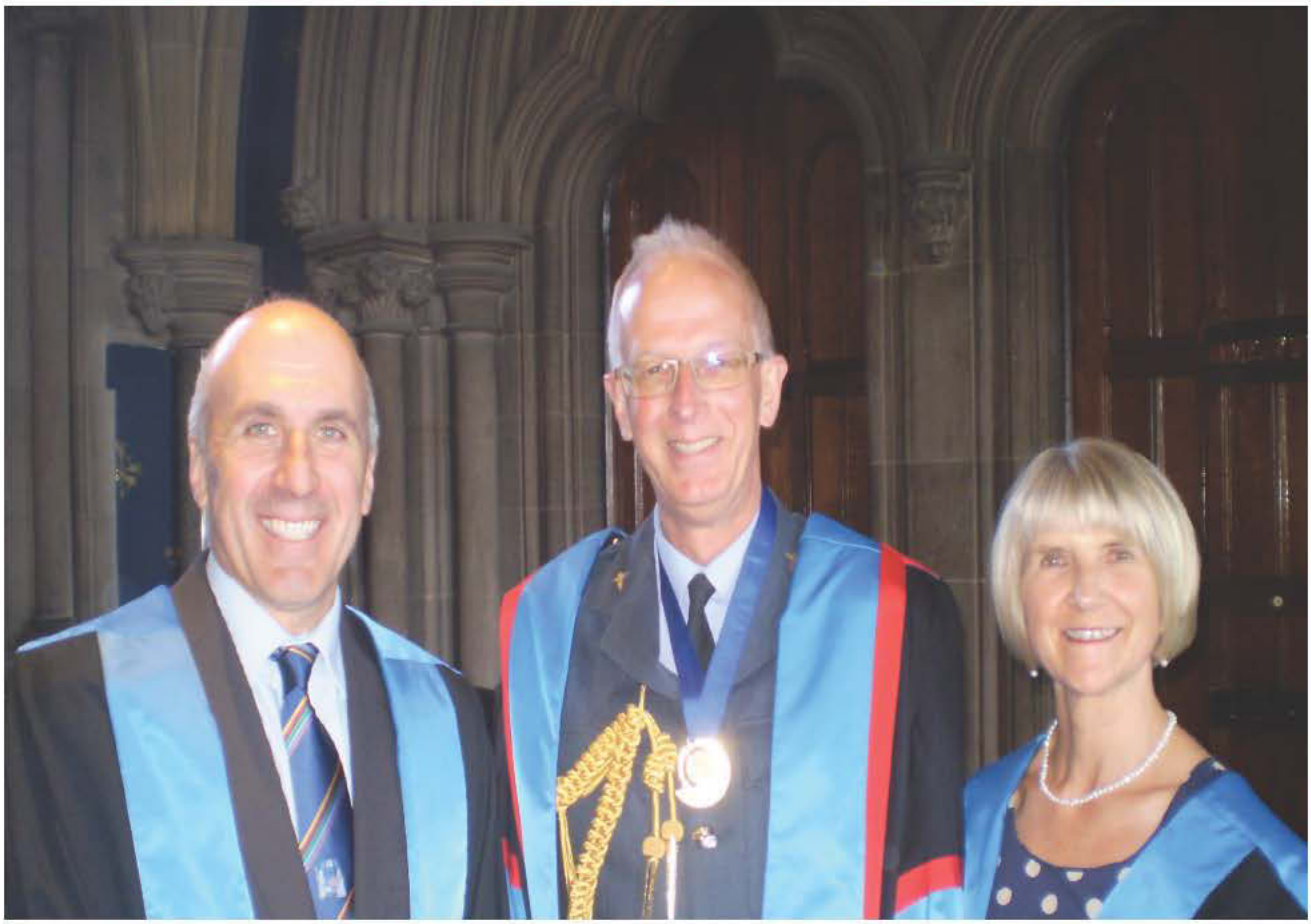
- **NEVER** ignore a fire alarm, including an announced fire evacuation drill
- Earplugs may delay guest arousal in the event of an alarm or safety announcement (our travellers use these especially if they are on a busy floor or their room is near the elevators)
- Keep the room key on your bedside locker and carry it with you in the event of a fire evacuation
- Check the temperature of the door handle before opening the door (use a towel if it is hot)
- Close all doors behind you as you make your way to the nearest available exit
- **NEVER** use the elevator in the event of a fire
- Crawl on the floor if smoke blocks your view – it will be cooler and your visibility will be better

If flames impede your escape:

- Place a wet towel at the base of the door
- Switch off fans and air conditioning in the bedroom
- Attempt to contact the fire services
- Wait at the bedroom window and signal with a light until you are rescued

Dr. Gerard Flaherty

CONGRATULATIONS



Conor Maguire and Ann McDonald presented with fellowship by Group Captain Andy Green, Dean Faculty of Travel Medicine.

Congratulations to our Society's President, Dr. Conor Maguire, for having been elevated to Fellowship of the Faculty of Travel Medicine at a recent Admission Ceremony in the Royal College of Physicians and Surgeons of Glasgow.

Conor joins other members of TMSI who have also received this honour from the Faculty, including Dom Colbert, Graham Fry, Peter Noone and Simon Collins. This is a very significant personal achievement for Conor and it is a fitting recognition of his commitment to travel medicine practice and education throughout his distinguished career in general practice.

Conor holds both the Certificate in Travel Health from the International Society of Travel Medicine and a Masters in Travel Medicine from Glasgow. As a member of the local organising committee he was instrumental to the success of NECTM4 which was hosted by the TMSI in Dublin in 2012. He has also represented the TMSI at major international travel medicine conferences. He is a long-serving member of the Executive Board of TMSI and has been to the fore in its educational efforts, including serving as a very capable Editor of Taisteal for many years.

Conor has always maintained excellent currency in his knowledge of the subject and he has always been very generous in sharing this knowledge and his many experiences as a GP with a special interest in travellers' health. You would do well to find a more enthusiastic travel medicine clinician than Conor.

On behalf of your friends in the TMSI, well done, Conor!

Dr. Gerard Flaherty

WHERE DO YOU GO....

When did you first catch the travel bug?

When I was 16 years old I went to Costa Rica for one year as an exchange student. I lived with a Costa Rican family in a small town in the North Western Province of Guanacaste and I went to the local secondary school. It was probably one of my most life shaping experiences and woke my passion for travelling and interest in the world and different cultures.

What do you most like about travel?

Leaving all the daily routines behind and open the mind to different lifestyles and cultures. I very much enjoy camping and living with only the basics.

How extensively have you travelled?

During my childhood and youth we travelled throughout Europe. I returned to Costa Rica a few times and I have travelled throughout South America and parts of Central America, Nepal, Israel, Ukraine, North America, East Africa. I have also lived and worked in Tanzania, Uganda, Bolivia and Spain.

Which country did you most enjoy visiting?

I have very rich memories of most of the countries I have visited but the two countries which come to my mind most would be Uganda and Nepal.

What was your favourite city to visit?

I like Berlin a lot. I have spent a few months living there and it has a fascinating history. It has lots of interesting 'back yard' cultures. Each 'Kiez' of the city seems more like a community in itself. In summer it is a fairly green city and I loved exploring it on a bike.

Are you an adventurous traveller?

I would say yes as I do like being outdoors a lot, so I have spent quite a few holidays camping in the wilderness and done several long distance treks in Europe, Africa, Nepal and Latin America. In Uganda we camped next to hippos and crocodiles and had to make sure we didn't put our tent in the middle of the beaten Elephant track to the water. I also enjoy outdoor activities like Kayaking and rock climbing.

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

The part I probably least enjoy is the packing beforehand.

What can travel teach us about ourselves?

It makes us reflect about our own culture, our own habits and the 'microcosmos' we live in.

Can you give us one useful travel tip?

Travel light! In my experience I have often taken too many things on my trips, which I did not use in the end. So gather all the things out you want to take and then take only half of it!

Have you any interesting trips coming up?

Having two young children we are not doing anything too exotic at the moment. Being German we have a little VW Campervan, which we are currently touring around with through Wales and the Yorkshire Dales.

Dr. Astrid Weidenhammer

WHAT'S IN THE JOURNALS?

There are four journals with travel medicine in the title – Journal of Travel Medicine (JTM; 2015 impact factor 1.868*), Travel Medicine and Infectious Disease (TMID; 2015 impact factor 2.192), International Journal of Travel Medicine and Global Health (IJTMGH; free open access journal based in Iran), and Tropical Diseases, Travel Medicine and Vaccines (open access journal with publishing fees for authors). Both TMID and JTM have enjoyed significant increases in their impact factors which were recently announced. This should result in even higher quality articles appearing in the journal but possibly also a higher rejection rate for authors submitting manuscripts.

TMID is affiliated with the Faculty of Travel Medicine in Glasgow and its Editor-in-Chief is Professor Patricia Schlagenhauf, originally from Wicklow but living and working in Zurich, Switzerland. JTM is associated with the International Society of Travel Medicine and its Editor-in-Chief is Professor Eric Caumes from France. Both are highly respected as researchers and journal editors. I currently sit on the editorial board of TMID and I regularly review articles for both JTM, TMID and IJTMGH. Journal reviewers and editorial board members serve in a voluntary capacity and do not receive any payment or expenses for their efforts. It is an enjoyable and stimulating activity and it is rewarding to see a paper which you have reviewed published in the journal. Quality journals such as these subscribe to the guidelines for journal editors established by COPE, the Committee on Publication Ethics (http://publicationethics.org/about).

Journal Editors-in-Chief, Patricia Schlagenhauf (TMID) and Eric Caumes (JTM)

In this and future issues of Taisteal, I will offer a synopsis of the highlights from articles published in the most recent issue of the two leading travel medicine journals. Both journals are published online, with JTM now having a monthly issue since it migrated to Oxford University Press and TMID a bimonthly publication from Elsevier Publications. Access to TMID is free for Affiliates, Associates, Members and Fellows of the Faculty of Travel Medicine, and ISTM members enjoy free access to JTM, but both journals are available in most Irish university e-libraries

TRAVEL MEDICINE and INFECTIOUS DISEASE

The May-June issue of TMID features a timely article on the anticipated health risks of travel to the 2016 Rio Olympic Games, drawing on data from a prospective case-control airport survey conducted at Frankfurt International airport in advance of the 2014 FIFA World Cup. This is accompanied by an editorial on the subject written by Patricia Schlagenhauf with Dipti Patel and Vanessa Field from NaTHNaC in the UK and presented as a checklist of travel health precautions for visitors to Rio. My own review article on altitude training for elite endurance athletes is kindly

provided by the journal as a free article which you can read at your leisure at http://www.travelmedicinejournal.com/article/S1477-8939(16)30007-2/pdf. Sexual risk-taking during travel abroad is the subject of a cross-sectional survey among young people in Sweden by Sundbeck et al.

A group of researchers from Madrid in Spain remind us to consider brucellosis in ill returned travellers who may have consumed unpasteurised dairy products, especially goat and sheep milk and cheese, in endemic countries such as Turkey. They present a case series and literature review on the subject. Rhodes and colleagues report cases of brucellosis in three immigrants travelling from the Horn of Africa who had drunk camel milk during their travels. Nick Beeching from the Liverpool School of Tropical Medicine advises us in his editorial to include mention of human brucellosis in pre-travel consultations. Kong et al. describe a case of melioidosis occurring in a diabetic man from Papua New Guinea. This is an infectious disease caused by the Gram negative bacterium Burkholderia pseudomallei and transmitted by direct contact with infected mud or water in endemic areas, including Thailand and northern Australia. It presents with fever, joint pain, chest pain and cough, and is another reason not to walk barefoot during travel. It is more common in patients with diabetes, thalassaemia and chronic kidney disease. Treatment of active disease is with intravenous ceftazidime and surgery is sometimes required when abscesses occur.

Zika infection is still in the news and Rodriguez-Morales and co-workers in Colombia provide a useful editorial which gives insights into the co-infection of zika, dengue and chikungunya in the Americas. Avitourism had not appeared in the travel medicine literature until I reported in this issue of the journal on a study I conducted with one of my medical students from Malaysia (Abdul Shameel Abdul Shukur) on the pre-travel health warnings provided to international birdwatchers by commercial tour companies. The diverse range of habitats explored by birdwatchers puts them at risk of traumatic injuries, animal bites, envenoming (I use this term in deference to the legendary Professor David Warrell who denounces the use of the alternative 'envenomation'!), as well as numerous vector-borne infections such as malaria. Birds, as we know are, by and large, entirely non-threatening and live in admirable harmony with other species. Possible exceptions include being dive bombed by the Great Skua (but only if you get too close to its eggs) and receiving a potentially fatal kick from the Southern Cassowary, an intimidating native of Australia and Papua New Guinea! A follow up study will reinforce the undoubted health benefits of birdwatching for the mental health of the traveller.

The current issue of JTM is the May issue as the June issue had not been published as of 22 July 2016. Schönenberger et al. report on a study which highlights the unpredictable nature of checks on yellow fever vaccination certificates by immigration officals in Tanzania. They discovered that certificate inspections were unsystematically conducted and much more common at land border crossings than at airports, especially in Dar es Salaam and Zanzibar. A somewhat reassuring study of adverse events associated with yellow fever vaccine over a 7 year period in the US showed that the anaphylaxis rate was 1.3 per 100,000 doses and highest in persons 18 and younger, with serious adverse events occurring in 3.8 per 100,000 doses. Rates of serious adverse events were more common in elderly vaccinees, with a rate of 6.5 and 10.3 per 100,000 doses in persons aged 60-69 and 70 years or older, respectively. A study of compliance rates with personal protective measures against mosquito bites in regions endemic for dengue, chikungunya and malaria found that use of insect repellents was more common in female travellers, where mosquitoes were observed during travel, and during the rainy season.

Case reports in the journal describe three cases of trichinellosis linked to polar bear meat consumption in Greenland (we don't see that every day!); an outbreak of varicella in 31 Sudanese refugees to Calais in France, and an unfortunate Italian traveller who contracted, wait for it, Campylobacter infection, giardiasis and hepatitis E from food and water ingestion during a 5-day trip to India. The latter reminds us that even short stays can present significant health risks to travellers and we should not allow them to become complacent.

I contributed two Perspective articles to this issue of the journal. I would encourage TMSI members to consider writing a 1000 word Perspective article with 10-15 references on a controversial or novel topic in travel medicine.

My colleagues on the TMSI Executive Board would be delighted to collaborate with you so please, if you have an idea, feel free to run it by me and we can take it from there. The first of my articles presents my views and those of a forensic medicine colleague on the medicolegal risks of travel medicine practice – not our favourite topic surely but one which is of great importance nonetheless. The second of my Perspective articles related to the "missing link" of introducing travel medicine into the undergraduate medical curriculum at NUI Galway in the form of special study modules. Dr. Watcharapong Piyaphanee discussed his experiences of introducing the world's first 3-year residency training programme in travel medicine in Thailand. We should take note of his successful efforts. Military medicine and intensive care medicine are now being recognised as new specialties by the Medical Council in Ireland, why not travel medicine? We were pleased that those luminaries of travel medicine, Phyllis Kozarsky and Robert Steffen, were invited to write an editorial to accompany the two education and training-related articles. Entitled 'Travel medicine education – what are the needs?', the editorial provides food for thought about travel medicine as a distinct specialty and the increasing complexity of its subject matter, including decisions on poly-morbid travellers and the recognition and management of emerging travel-related diseases. That's all for this issue. We will do another round up in our next issue of Taisteal.

Dr. Gerard Flaherty

**Author's note*: The impact factor of a journal is a widely used metric which equals the average number of times articles in that journal have been cited in the literature over the preceding two years. The higher the impact factor the greater the influence of the journal on the scientific community. Impact factors are published by Thomson Reuters (and some other groups) on an annual basis and journals strive towards increased values, with researchers being guided by this metric in deciding their target journal. External grant award agencies also consider the impact factor of journals a grant applicant has published in previously.

REPORT FROM NECTM6 2016 LONDON

6TH NORTHERN EUROPEAN CONFERENCE ON TRAVEL MEDICINE

The Queen Elizabeth II Centre, London, UK - 1st - 4th June 2016

The 6th Northern European Conference on Travel Medicine was held in the Queen Elizabeth 2nd Centre in London from June 1st to 4th.
NECTM conferences are biennial and attract a wide range of delegates including Travel Medicine physicians, nurse practitioners, GP's, scientists, pharmacists, educators and veterinarians.

Travel Medicine conferences draw on the experiences and expertise of a broad church of medical professionals and this meeting of minds is always stimulating and informative. London NECTM lived up to expectations and delivered a wide ranging conference with content suitable for all groups of attendees, whether new to the discipline of Travel Medicine or research scientists.

A pre-conference half day workshop focused on Travel Medicine foundation essentials with presentations covering Communication, Risk assessment, Immunisation, Malaria and Travel during Pregnancy and Children's travel risks.

It may be surprising to see veterinarians in the list of delegates and speakers, yet animal health is inextricably linked with human health and the forces of globalisation, climate change and increased international travel play an important role in the spread of zoonoses. Many emerging diseases have animal hosts. The concept of "One Health" is well established and human welfare should not be considered in isolation from environmental concerns and animal health. One Health is likely to become increasingly important as Governmental and International agencies recognise the benefits of cooperation between environmental, medical and veterinarian experts.

Professor Dominic Mellor a Veterinarian from the University of Glasgow gave a presentation on zoonoses and opportunities for cooperation between professionals. He also works for Health Protection Scotland as an advisor on zoonoses.

The importance of tailoring risk assessment and advice for risk groups was comprehensively covered in Symposium 8 -"Travelers Through the Ages", with presentations outlining best practice in preparing the elderly, paediatric travellers and gap year students for travel.

Zika virus was a recurring theme during the conference. This emerging threat coincides with the Olympic games and the risk of accelerated spread resulting from mass movement of people is a major health concern internationally. It is considered that the majority of cases of Zika are subclinical or mild in severity, however a major public health risk involves Zika exposure during pregnancy through mosquito bite or through sexual transmission. Zika's link with Microcephaly was emphasised although some speakers urged caution in interpreting data in an evolving outbreak.

Professor Patricia Schlangenhauf from Zurich University spoke about the possibility of Zika spread to Europe where Aedes Aegypti mosquitoes have already been found to be capable of carrying Chikungunya and Dengue viruses. The scale of travel from South America internationally is likely to be a major factor in the spread of Zika.

Dr James Logan from the London School of Hygiene and Tropical Medicine spoke about insect bite avoidance and prevention and outlined the limitations of currently available agents. Insect repellants although effective are limited by their relatively short term efficacy, problems with compliance and cosmetic unattractiveness with many users. He outlined future strategies including long lasting insect repellents and special clothing which may significantly improve bite protection for travellers.

Medical Tourism has become an important subject for Travel Medicine practitioners and Symposium 4 was dedicated to the subject. Drivers such as cheaper travel, globalisation and the Internet were discussed and the benefits and risks of medical tourism were outlined. Dr Gerard Flaherty presented a talk on Transplant Tourism and Organ Trafficking and spoke about this growing area in medicine. Although organ donations are tightly regulated in some countries, there is a lack of transparency in many countries with respect to the source of donations and it is likely that many medical tourists may not be aware of this.

Symposium 2 was dedicated to Traveller Etiquette, how international travellers behave abroad, cultural nuances and sensitivities and also changing travel trends. The growth in exotic travel to destinations previously not a target for mass tourism has many environmental, economic and social implications for these often remote societies. Dr. Richard Weller from Edinburgh University spoke about sun exposure and how we advise travellers. In a presentation titles " Mad Dogs and Englishmen—Is sun exposure bad for you?", he challenged the orthodoxy of how travel medicine practitioners advise travellers on sun exposure. Whilst avoiding excessive exposure and sunburn remains important, he outlined the scientific evidence of benefit from sunlight exposure including potential links between lack of sun exposure to hypertension, type 2 diabetes mellitus, cardiovascular disease and metabolic syndrome. He suggested that Vitamin D supplementation has no benefit for these conditions and that sunlight may confer health benefits through a mechanism other than Vitamin D synthesis.

VFR (Visiting Friends & Relatives) travel is growing as migration patterns change and mass immigration movements of displaced populations and refugees continue. Dr. Ron Behrens from the London School of Hygiene and Tropical Medicine suggested that the traditional definition of VFR travel may be too restrictive and that travel with an intention to visit friends and relatives where there is a health or socioeconomic gradient between countries may be a more useful definition.
Professor Mike Starr a consultant paediatrician from the Royal Children's Hospital Melbourne outlined the challenges facing VFR traveller children. VFR Children frequently do not consult pre-travel, cost of vaccinations may be a barrier to appropriate pre-travel preparation and they are more susceptible to many travel risks including accidents, animal bites/rabies, travellers' diarrhoea, dehydration and excessive sun exposure.

In their presentation on Vaccine Dilemmas, Mrs Alexandra Grieve and Ms Lorna Boyne from the Royal College of Nursing and Health Protection Scotland respectively, outlined the change in Yellow fever vaccine requirements and the recommendation by the WHO that Yellow fever vaccination certification is now valid for life. This recommendation is reflected in the International Health Regulations which member countries are expected to adopt.

Dr, Ilker Balkan from Istanbul University spoke about the challenges of dealing with refugee populations in his presentation" Health of Displaced People: Implications of the Syrian Conflict"
He outlined the Turkish experience, challenges of language barriers, lack of medical data such as vaccination records, social barriers to providing care and lack of awareness of indigenous illnesses. Tuberculosis, cutaneous Leishmaniasis, measles and potentially polio are particular population risks to consider. Delegates were struck by his closing remarks:
"Refugees are Not a Threat—They Are Threatened" "We need to Respect Humanity rather than Borders"

There was a comprehensive Poster display of original travel medicine related research topics in addition to many industry stands which provided educational information and displays of a variety of travel related

products and services. A downloadable copy of Abstracts from invited speakers, free communications and posters remains available on the NECT website: www.nectm.com

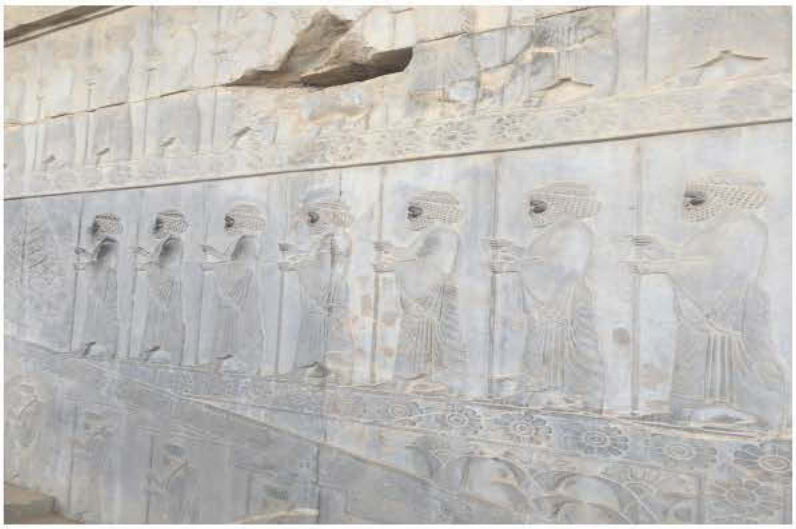
NECTM conferences are an exceptional educational tool and NECTM 6 in London did not disappoint in this regard. The camaraderie and spirit of cooperation experienced at previous conferences was very much to the fore in London and I am sure that NECTM 7 in Stockholm 2018 will continue the tradition. I would recommend NECTM conferences to practitioners of all levels.

Dr John Gibbons

IRAN – THE IMPRESSIONS OF AN IRISH VISITOR

*[**Editor's note:** the recent lifting of sanctions on Iran means that this extraordinary country is rapidly becoming more accessible to travelers. We should expect to see increasing numbers of patients attending for pre-travel consultations. In the spirit of better-acquainting TMSI members with this historic land, committee member Dr. Hakhamanesh Nikookam, himself an Iranian by birth, invited an Irish friend who had visited the country, to share her impressions of it with us].*

To visit Iran is to get an insight into a culture and civilisation that is both ancient and beautiful. From the petrified ruins of Persepolis to the intricate mosaics of the Jameh Mosque in Yazd, is a magical and mystical journey of discovery. A journey of self-discovery too when we learn that the founding principles of Zoroastrianism are to love what is good, avoid evil, tell the truth and respect others - surely basic principles with which we can all identify. The elemental fire which burns unquenched since 460 AD in the Temple at Yazd is testimony to this underlying creed of the Iranian people.



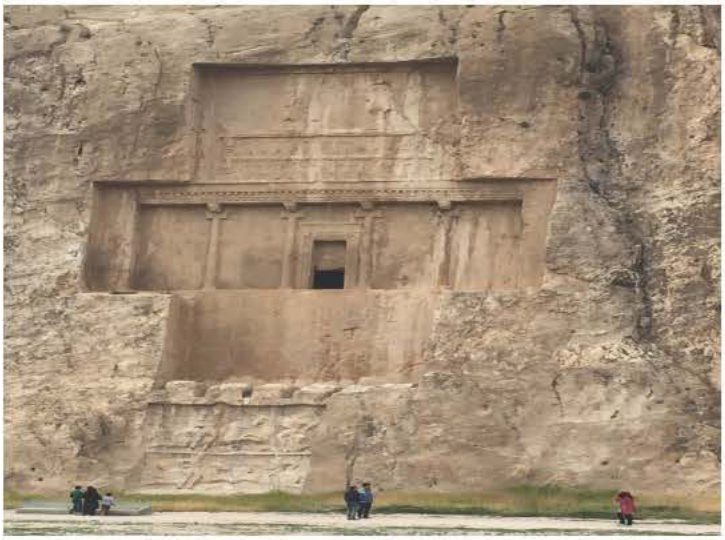
Bas-relief of delegates visiting the emperor Darius in Persepolis 520BC

And it is in Iran too that we find the first written declaration of human rights - sculpted in ancient Parsi script on the towering entrance to Persepolis. This ancient palace, founded by Darius the Great in 520 BC as the meeting place for the twenty-one member states of the Persian Empire, greets all who enter with a statement of respect which has been adopted by the United Nations in its charter on human rights. Despite being destroyed by Alexander the Great in 330 BC, Persepolis has retained its dignity - its ruins still stand proud in the vast desert plains.

Nearby Shiraz, 7th century city and erstwhile capital of Persia, is an essential stop for the tourist. The citadel of Karim Khan, with its four ornate towers, dominates the cityscape. The most memorable feature inside this 18th century fortress is the beautiful stucco work in the bathhouse.

Stroll through the Unesco listed Eram gardens ablaze with orange blossom while a nightingale sings blithely from the trees. Then on to the Bazar-e Vakil, commissioned by Karim Khan as part of his plan to make Shiraz into the successful commercial centre which it still is today. The wide vaulted avenues of this cruciform structure of yellow brick make this perhaps the finest bazaar in Iran.

There is something both mystical and joyful in the air at the tomb of Hafez, the 14th century poet whose highly structured rhyming couplets still inspire. Hafez meaning "one who has memorised the Koran", is a Sufi mystic who skillfully bridges the divide between sacred and profane. On one level his poems celebrate the pleasures of wine and courtly love; on another they reflect a yearning for union, through nature, with the divine. No wonder Iranians look to Hafez for solace and wisdom.



Naqsh-e Rostam tombs

The journey by road from Shiraz to Yazd not only takes in Persepolis but also the majestic tombs at Naqsh-e Rostam. Hewn into an enormous limestone rock formation, and high above the ground, the final resting places of Darius I, Darius II, Artaxerxes I and Xerxes I defy any interloper.

To arrive into old Yazd is to travel back in time. Situated in the heart of Iran and surrounded by the Kavir and Lut deserts, this ancient city retains the narrow streets and adobe structures which testify to its pivotal position on the international caravan routes or Silk Road to Central Asia and India. Marco Polo also dropped by in the 13th century on his way to China and called it the "good and noble city of Yazd." Visit a tea shop and ask to go up to the roof garden. There you get a view of gently undulating sun-baked rooftops, interspersed with badgirs or wind towers - a sophisticated and effective system of air-conditioning. And speaking of sophistication, the underground water system in Yazd pre-dates Roman aqueducts, with qanats or conduits extending to 45km.

When we reach Isfahan we discover another depth and wealth of art and history. This most famous of Persian cities was called Isfahan nesf-e Jahan, (Isfahan is half the world) due to its splendour and international renown in the 16th century. The magnificent central town square - superseded in size only by Tiananmen Square in Beijing - is surrounded by world heritage architecture, with a multi-faceted and lively Bazaar running through it. This is no ordinary bazaar. It houses a wealth and variety of artefacts and artisans. Silversmiths, woodturners, metalworkers, copper beaters all ply their trades here. We spoke with one young metalworker who started his apprenticeship at ten years old. He is the first in his family to do this work and is proud to keep the ancient art alive.

The square also contains a polo pitch, Iran being the birthplace of the sport adopted by the British centuries later.

Rooftop with badgir in Yazd

Talar-e Ashraf (Ashraf Hall) gives us a glimpse into the wealth and colour of life in the times of the Safavid monarchs - Shah Abbas II and Shah Soleiman, 1642 - 1694 AD. In the lively frescoes found here musicians perform on varied instruments, ladies dance, food and wine abound, while the Shah sits centre stage.

For an insight into Shah Abbas' contribution to religious architecture, visit the Sheikh Lotfollah Mosque. The enormous dome represents a peacock's tail, its body suggested, with ingenious precision, by the light from a tiny central aperture.

Top off your Isfahan experience by checking into one of the magnificent suites in the old section of the historic Abbasi Hotel, once a caravanserai - a caravan stop on the old Silk Route from the East. A unique and very special experience.

To visit Iran is to discover another world. The more we saw, the more we realised how much we had not seen. This is not just the tip of an iceberg; it is more like skimming the surface of a deep well of art and civilisation. We saw enough for a first visit - it takes time to absorb so much beauty, history and culture. But the warmth of the welcome we received wherever we went, the wonderful food in traditional restaurants, and the knowledge that there is much more to be experienced convinces us that we must come back.

Barbara Duff

GLOBAL ROUND-UP

CHIKUNGUNYA VIRUS: According to data from the Pan American Health Organisation (PAHO) a total of **2578** suspected and **66** confirmed cases of chikungunya virus (CHIKV) infection have been recorded in **Guatemala** between January to early July 2016.

17,766 suspected cases of chikungunya virus (CHIKV) infection have been recorded in **Colombia** between January to mid July 2016. **132** of these cases have been confirmed as CHIKV.

805 suspected and **18** confirmed cases of chikungunya virus (CHIKV) infection have been recorded in **French Guiana** between January to early June 2016.

1647 suspected cases of chikungunya virus (CHIKV) infection have been recorded in **Costa Rica** between January to early July 2016.

280 suspected and **1528** confirmed cases of chikungunya virus (CHIKV) infection have been recorded in **Ecuador** between January to mid July 2016.

13,524 suspected cases of chikungunya virus (CHIKV) infection have been recorded in **Honduras** between January to mid July 2016. **4675** suspected and **453** confirmed cases of chikungunya virus (CHIKV) infection have been recorded in **Nicaragua** between January to late June 2016.

52 imported cases of chikungunya virus (CHIKV) infection have been recorded in the **United States** between January to mid July 2016.

3164 suspected and 317 confirmed cases of chikungunya virus (CHIKV) infection have been recorded in **Argentina** between January to mid July 2016.

Source: Pan American Health Organisation

JAPANESE ENCEPHALITIS: India. A potential resurgence of Japanese encephalitis (JE) in flooded districts of Assam; the state has reported over **295** JE positive cases with **66** casualities to date.

Source: The North East Today

LEPTOSPIROSIS: India. Following a surge in cases of leptospirosis the Brihanmumbai Municipal Corporation (BMC) collected random blood samples of dogs, cows, buffaloes and cats from the Mumbai; the majority of the cattle samples tested positive for leptospira bacteria. The BMC reported that over 15 people have tested positive for leptospirosis in the past week, and that one person died from infection in July 2016.

Source:ProMED Mail

HFMD: Thailand. The number of hand, foot and mouth disease (HFMD) cases in Bangkok has risen to over 6000 from January to July (2016), according to the Bangkok Metropolitan Administration. The number of cases this year (2016) doubled from that of the same period last year (2015). HFMD is a common viral illness which spreads rapidly. Transmission is via direct contact with nose and throat secretions and faeces if an infected individual and by aerosol droplet spread. Contact with infected children should be limited and crowded situations avoided; personal hygiene and handwashing is paramount in reducing transmission.

Source:ProMED Mail

CHOLERA: Dominican Republic. The Pan American Health Organisation (PAHO) has reported **894** suspected cholera cases reported and **17** related deaths in the Dominican Republic between January to late June 2016. These reported cases and deaths exceed the reported cases and deaths in the same timeframe in 2014 and 2015.

Source: Pan American Health Organisation

Travel Medicine Conference Calendar

7th Regional Conference of the International Society of Travel Medicine
Date: 28 September - 1 October 2016
Port Elizabeth, South Africa
Web: www.istm.org

Travel Medicine Society of Ireland - half-day meeting
Date: 3 September, 2016
Location: Rochestown Park Hotel, Douglas, Cork
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 Masterclass
Date: 5 November, 2016
Location: Clarion Hotel, Liffey Valley, Lucan, Dublin
Time: 9:00am - 5:00pm
Fee: Members €45.00, Non-members €65.00. Places limited
For further information, please contact Anne at 045 890 127 or annehredmond@eircom.net

Hygiene and Epidemiology Havana 2016
Date: November 15 to 18
Venue: Havana, Cuba.
For further information and the details: www.http://higepidem2016.sld.cu/index.php/higepidem/2016/

4th Tropical Medicine Excursion
Date:30 November – 10 December 2016, to Ghana, West Africa.
In collaboration with various teaching hospitals in Ghana and Kay Schaefer (MD, PhD, MSc, DTM&H), Cologne, Germany. 11 days round-trip excursion. Includes individual on-site bedside teaching, laboratory manuals (hands-on microscopy on parasites in the blood, stool, urine and skin), field excursions and lectures. Accreditation: 60 CME contact hours by the Medical Association, Düsseldorf, Germany. Official language: English. www.tropmedex.com

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