TAISTEAL

Volume 19

Issue 1

Spring 2019

NEWSLETTER

ed. A. Weidenhammer

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

We look forward to seeing you in 2019

SEASONED TRAVELLERS – THE NEW ISTM OLDER TRAVELLER INTEREST GROUP

It is an exciting time to be an older traveller. The travel industry recognises the wanderlust of this group of travellers and numerous tour operators specifically tailor their tourism packages to suit the needs and preferences of senior travellers. As a result, there are few destinations out of the reach of the modern older explorer, travel funds permitting of course. Older travellers differ in somer host factors, such as immunosenescence, medical co-morbidities and polypharmacy. In addition to the increased risk of certain travel-related infections, older travellers may also develop waning immune responses to vaccines or be at increased risk of yellow fever vaccine-associated adverse reactions. In my experience though from the travel clinic, the older traveller tends to be more organised and have a more certain travel itinerary than younger adventurers, which surely must confer a degree of protection from travel-related injuries and infectious exposures.

I am one of a quartet of ISTM members (with Robert Steffen, Joe Torresi and Andrea Rossanese) who have collaborated in creating the latest addition to the ISTM interest groups. Our charter proposes the following:

- To provide a forum for exchange of ideas between ISTM members interested in travel health issues for older travellers
- To develop specific pre-travel health recommendations for older travellers
- To discuss the need for specific diagnostic and therapeutic post-travel measures for this population
- To advance the scientific evidence base for the practice of travel medicine for older travellers
- To encourage research into the spectrum of health issues in older travellers and in developing more effective vaccination strategies
- To develop educational programs and sessions on specific issues affecting older travellers

The level of interest in this nascent group from ISTM members has been very gratifying. Currently, we are at the stage of putting out a call for nominees to join our Council. You can expect lots of activity in this area at future CISTM conferences (the topic is already on the programme for CISTM16 in Washington DC) and other ISTM events. If you are a member of ISTM with an interest in the health needs of the older traveller, or if you are an older traveller (hopefully we will all fall into that category some day!), keep an eye out for news and activities on the ISTM website. Further information is available from our recent publication in Journal of Travel Medicine, A golden age of travel: advancing the interests of older travellers, which you can view for free at: https://academic.oup.com/jtm/article/25/1/tay088/5103478. You may also be interested to read the chapter on the older traveller which I have co-authored with Dr. Kathryn Suh in the 4th edition of Keystone's Textbook of Travel Medicine, which was just published earlier this year.

Prof. Gerard Flaherty

TEST YOUR KNOWLEDGE – MULTIPLE CHOICES QUESTIONS IN TRAVEL MEDICINE:

By Dr. Joseph Sim.

1. Medicines and travel:

(A) Legal requirements / enforcements for carrying personal medicines across international borders are highly inconsistent.

(B) It is advisable for travellers to bring along prescriptions for their medications & a letter from their doctors for border control checks.

(C) Counterfeit medications are uncommon abroad and it is easy for buyers to detect counterfeit medications.

(D) It helps to take all medications out of the original packaging / container for easy control checks at international borders.

2. Histoplasmosis:

(A) Is a bacterial infection caused by Histoplasma that grows in soil contaminated by bird / bat droppings.

(B) A person who was previously exposed to Histoplasmosis is not immune to subsequent infections.

(C) Majority of infected individuals exhibit severe symptoms 3 to 17 days after exposure.

(D) Histoplasmosis is not contagious and cannot be spread between people except in rare cases where the infection is passed through an organ transplant with an infected organ.

3. Travelling with children:

(A) Accidents and injuries are the greatest cause of serious illness and death in children travelling abroad.

(B) Due to pressure changes on plane take-offs and landings, approximately 15% of children will get ear ache.

(C) It is estimated that 40% of people bitten by suspected rabid animals are children and rabies disease may progress more quickly in children as they are more likely to be bitten around the face and head.

(D) Motion sickness is not common in children unless the children are sick pre-travel.

4. Rotavirus:

(A) Worldwide, rotaviruses are the commonest cause of community-acquired gastroenteritis in children.

(B) Death rates from rotavirus infection are high even in countries where there is ready access ton oral and parenteral rehydration.

(C) In Ireland, rotavirus is a notifiable disease.

(D) Children may get infected from rotavirus more than once, even those who are vaccinated.

5. Venous Thromboembolism (VTE):

(A) Is always symptomatic.

(B) Immobility of more than 4hr increases the risk for VTE in travellers.

(C) Asprin is useful in preventing both arterial thrombosis and venous thrombosis during long haul travel.

(D) The use of properly fitted below knee graduated compression socks providing 15 to 30mmHg of pressure at ankle reduce the risk of symptomatic VTE.

6. What Country is this - Hints:

(A) It is home to the world's largest rain-forest and the largest river by volume.

(B) High altitude travel destinations in this country are increasingly popular – there are 37 mountain peaks that are higher than 6000m.

(C) There is on-going risk of Zika virus transmission in this country.

Answers on page 6

Foundation and Diploma Courses in **Travel Medicine**

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
TRAVEL MEDICINE

Foundation Course in Travel Medicine

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

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

Topics covered include:

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

Diploma in Travel Medicine (DipTravMed)

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

The course includes:

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

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

The UK's only multidisciplinary Royal College

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

Course content and curriculum: Ann McDonald or Clare Henderson
ann.mcdonald@rcpsg.ac.uk | clare.henderson@rcpsg.ac.uk
+44 (0)141 227 3239

Travel Medicine Courses, Faculty of Travel Medicine
Royal College of Physicians and Surgeons of Glasgow
232-242 St Vincent Street, Glasgow, G2 5RJ, UK
www.rcpsg.ac.uk/travel-medicine

The Royal College of Physicians and Surgeons of Glasgow is a charity registered in Scotland. Charity registration number: SC000847 | 04.13

THE BREATHLESS TREKKER

Fig. 1. Trekking to the beautiful Ama Dablam ('Mother's necklace') Base Camp (4570m) in Nepal (2005)

Trekkers to high altitude are expected to feel short of breath during exertion. This has been termed "physiological dyspnoea". The minute ventilation increases at altitude as a result of hypoxic stimulation of the peripheral chemoreceptors in the carotid bodies. Trekkers should feel relatively comfortable at rest, however, although the degree of comfort will depend on their underlying cardiovascular fitness and any pre-existing cardiorespiratory disease. I am often asked about patients with asthma at high altitude. The cleaner air, reduced house dust mite population, reduced resistance to airflow and production of chemical mediators which favour bronchodilation all combine to improve asthmatic symptoms in many patients. Some asthmatic trekkers whose condition is exercise-induced or exacerbated by cold air may tolerate high altitude exposure poorly, however. Some trekkers may experience excessive hyperventilation at altitude if they are anxious but typically their shortness of breath will be accompanied by paraesthesiae in the extremities or light-headedness.

Travellers to high altitude may have at least two additional risk factors for pulmonary thromboembolism – a recent long haul flight and the hyperviscosity that results from reduced plasma volume and increased red cell production at altitude. Female trekkers may be taking the oral contraceptive pill, sometimes to control menstruation while at altitude, so there may be further risk factors for venous thromboembolism in some trekkers. Anaemic travellers may experience poor exercise tolerance at high altitude and it is recommended to correct iron deficiency if this is detected in advance of travel to high altitude destinations. Travellers with COPD and interstitial lung disease do not tolerate hypobaric hypoxia well and should be advised to limit their exposure to intermediate altitudes. Pneumonia can also occur during wilderness travel and this must also be considered in the differential diagnosis of the breathless trekker, especially if they are smokers.

Differentiation of pneumonia from high altitude pulmonary oedema (HAPE) can be challenging. HAPE used to be described as "the pneumonia of the mountains" in the distant past in South America. HAPE results from uneven hypoxic pulmonary vasoconstriction leading to pulmonary hypertension and a patchy non-cardiogenic pulmonary oedema. Symptoms typically appear on the second night at an altitude above 4000m but it can occur at lower altitudes in susceptible individuals. Affected individuals are short of breath even at rest and typically lag behind others in the trekking party. They feel very lethargic. A dry cough progresses to a productive cough with expectoration of blood-tinged frothy sputum. Examination will reveal tachypnoea, tachycardia, central cyanosis and coarse crackles throughout both lungs, with particular involvement of the right middle lobe. The presence of fever may confuse the condition with pneumonia but fever is also well described in HAPE owing to the inflammatory cytokine production associated with the condition. A portable pulse oximeter will reveal a capillary oxygen saturation level well below the mean of the acclimatised trekkers in the group. Patients with HAPE are at increased risk of acute mountain sickness and high altitude cerebral oedema by virtue of their increased hypoxaemia.

There is no substitute for early descent in these trekkers but sometimes there are unavoidable delays owing to weather, difficult terrain or problems mobilising the required support from porters to facilitate descent. Where a portable hyperbaric chamber is available, the HAPE victim should remain in the pressurised chamber for up to 4 hours while arrangements for descent are being made. Nifedipine 30mg slow release is the drug of choice in these patients but ensure that they are not dehydrated first so that their systemic arterial blood pressure will tolerate the agent. Most amateur trekking groups will not be able to carry oxygen cylinders but where available both oxygen and nifedipine will act to quickly lower pulmonary artery systolic pressure. The role of the beta-2-agonist salmeterol in clearing alveolar fluid and of phosphodiesterase-5-inhibitors such as tadalafil in reducing pulmonary artery pressure are well recognised but, in practice, nifedipine is used most often in these patients.

Travellers who have developed HAPE should be careful not to return to high altitude on the same trip once recovered to avoid the development of re-ascent HAPE and ideally they should not travel to the altitude at which HAPE arose in future. Preventive measures include not exceeding the recommended rate of ascent, avoiding high altitude exposure when suffering an upper respiratory tract infection, warming inspired air with a scarf and avoiding undue exertion at high altitude. High-risk travellers can be offered nifedipine 30mg twice daily as chemoprophylaxis. Travellers with a medical history of any condition which causes pulmonary hypertension or with a single pulmonary artery are at high risk of developing HAPE and should therefore avoid travel to high altitude.

Reference: Flaherty GT, Kennedy KM. Preparing patients for travel to high altitude: advice on travel health and chemoprophylaxis. Br J Gen Pract 2016; DOI: 10.3399/bjgp16X683377.

TEST YOUR KNOWLEDGE ANSWERS:

Questions/Sections	A	B	C	D
1 (Medicines & travel)	True	True	False	False
2 (Histoplasmosis)	False	True	False	False
3 (Children Travellers)	True	True	True	False
4 (Rotavirus)	True	False	True	True
5 (VTE)	False	True	False	True
6 (What country)	Peru			

IMPORTANT UPDATES TO THE RABIES CHAPTER IN THE IRISH IMMUNISATION GUIDELINES

Discussing the risk of Rabies is an integral part of most Pre-Travel consultations.
The Rabies chapter of the Irish Immunisation Guidelines has recently been updated following changes in the guidance from the WHO. I would like to highlight the most important changes for our day to day practice:

1) The schedule for Rabies Pre-Exposure immunisation has up to now been one dose of >2.5IU on days 0, 7 and 21 or 28 administered by IM injection into the deltoid region. A dilemma has always been the last-minute traveller who is leaving in less than 21 days and therefore would not be able to complete the full Rabies Pre-exposure immunisation course. For those travellers the option exists now to do an accelerated schedule on days 0, 3 and 7 which will give sufficient short-term protection for an imminent trip, but a booster at one year is required to complete the course and to provide long term protection.

2) According to the updated guidelines the duration of partial protection is now considered lifelong in most cases if a complete pre-exposure course has been completed (either on days 0,7,21or 28 OR 0,3,7 and 365). Therefore, those at infrequent risk of episodic exposure (like most travellers) who are fully vaccinated do not require further booster doses.
Booster doses are still recommended for certain higher risk groups who have a regular and continuous or frequent episodic risk of exposure (e.g. veterinarians, bat researchers, Rabies diagnostic workers) or for immunosuppressed patients who might have a suboptimal response to the vaccine.

3) The number of vaccine doses recommended for Post-Exposure prophylaxis (PEP) in immunocompetent individuals has been reduced to 4 doses on days 0,3,7 and 14-28 (previously 5 doses).
This implies that Immunosuppressed patients should still receive five doses of Rabies vaccine as PEP.
Depending of category of exposure, Rabies Immune Globulin might also be recommended (see table below from IGI chapter 18)

For further information on risk assessment and categories of exposure, refer to https://www.hse.ie/eng/health/immunisation/hcpinfo/guidelines/chapter18.pdf

	Unimmunised	**Previously immunised**
Category I exposure	Wash exposed skin No PEP required.	Wash exposed skin No PEP required.
Category II exposure	Wound washing and immediate vaccination: 1 dose IM on days 0, 3, 7 and day 14–28 (four doses) HRIG is NOT indicated	Wound washing and immediate vaccination: 1 dose IM days 0 and 3 (two doses) HRIG is NOT indicated
Category III exposure	Wound washing and immediate vaccination: 1 dose IM on days 0, 3, 7 and day 14–28 (four doses) HRIG is recommended	Wound washing and immediate vaccination: 1 dose IM on days 0 and 3 (2 doses) HRIG is NOT indicated.

Table 18.1 Post-exposure treatment following risk assessment Rabies risk (any age)

Astrid Weidenhammer


The 16th Conference of the
International Society of Travel Medicine
Washington DC
United States of America
5-9 June 2019
Travel Medicine
in a Changing Climate
(www.istm.org)

ALL ROADS ARE LEADING TO WASHINGTON DC

The 16th Conference of the International Society of Travel Medicine will be held in Washington DC from June 5th to 9th 2019. For those who have not visited the capital city of the USA, I would recommend it highly, having attended a conference there in 2007. It is a very well laid out city with so many fascinating sites of interest. It is also easily accessible from Ireland with direct flights from Dublin Airport with Aer Lingus, Lufthansa and United Airlines and convenient immigration clearance in Ireland.

The chair of the scientific committee, Dr. Blaise Genton from Switzerland, has worked hard to deliver an exciting and innovative programme for delegates. There will be plenaries devoted to climate change, antimicrobial resistance, arboviral infections and e-health in travel medicine. Symposia will include sexual health, air pollution, vaccines and immunocompromised travellers. The second Alan Magill Memorial Lecture on malaria will be delivered by Christopher Drakeley from the UK. The full scientific programme can be viewed at http://www.istm.org/cistm16program#symposia. I have been invited to co-facilitate a workshop on the special traveller with chronic illness with Dr. Andrea Rossanese from Italy, a good friend of the NECTM conference. For those of you who wish to sit the Certificate in Travel Health examination, there will be an opportunity to do so but you will need to register soon as places are filling quickly. Attending CISTM is an enjoyable way to get up to date in travel medicine practice, to learn about new approaches and recommendations arising from research, to challenge the experts, network with colleagues and make new friends from around the world.

My own four-year term as Counsellor on the ISTM Executive Committee will come to an end at the conference and I will take over as chair of the Publications Committee from Prof. Joe Torresi. My work with the Executive Committee has been very busy but very enjoyable and I am glad to see the ISTM in such a strong position as our President elect, Dr. Lin Chen from Boston, will take over the reins from Dr. Leo Visser. Lin will be an excellent president and the society is in safe hands under her leadership.

I encourage you all to register for CISTM16. Try to make time to visit the sights during your stay in Washington DC. I hope to see you there!

Prof. Gerard Flaherty

TRAVEL MEDICINE SOCIETY OF IRELAND
Executive Committee and Officers

President:	**Simon Collins**
President-Elect:	**Astrid Weidenhammer**
Hon. Secretary / Hon.Treasurer:	**Anne Redmond**
Newsletter Editor:	**Astrid Weidenhammer**
N.E.C.T.M. Scientific Committee	**Gerard Flaherty**
Officers:	**Conor Maguire**
	Gerard Flaherty
	Siobhan Grehan
	Patricia Brady
	Joseph Sim

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: 31st December 2019

The winner of the 2019 bursary is Dr. Mary Durcan.

The winner of the Dom Colbert Essay Prize 2019 is Timothy Siliang Lu, 2nd year medical student, National University of Ireland Galway.

The Essay is entitled: Unwanted Souvenirs: Antimicrobial Resistance and International Travel

Timothy will present his essay at the AGM in April.

Items for the newsletter can be forwarded to:

taisteal@tmsi.ie

or

anne.redmond@tmsi.ie