Autumn/Winter 2015

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
TRAVEL MEDICINE

emporiatrics

News, views and reviews

from the Faculty of Travel Medicine

In this issue…

www.rcpsg.ac.uk

Regulars

People

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Editorial

From Nepal to antibiotics

Welcome to another packed edition of Emporiatrics. It was lovely to catch up with so many colleagues at CISTM14 in Quebec – a great event and also a chance to discover what an amazing holiday destination Canada is—which is precisely what Carolyn Driver writes about on page 12.

Thanks go to Mike Jones, who demits office in October and celebrates his achievements in his valedictory Dean's letter on page 3. We wish Mike and his wife Elizabeth good fortune in their new endeavours.

NaTHNaC's Dipti Patel is featured in our In Focus interview on page 9. Ebola continues to dominate the news in our field and Kitty Smith went to Sierra Leone to see for herself. Her report is on page 10. Indeed, natural disasters often seem to strike the poorest regions and on page 5 Prativa Pandey relates her story of the Nepal earthquake and how the CIWEC clinic in Kathmandu rose to the challenge. We may think that domestic travel is a safe option for senior travellers, but on page 6 Irmgard Bauer shares her research on the hazards of getting away from it all on a 'local' but still remote island. Traveller's diarrhoea is always with us and, on page 8, Anu Kantele challenges us to rethink automatically prescribing antibiotics. Good news for travel health advisers in England is highlighted by Jane Chiodini on page 13.

My thanks as always to our contributors.

Sandra Grieve

Correction: In the Spring/Summer 2015 Edition, the BGTHA/FTM conference report inadvertently named Tania John as BGTHA Chair, a post currently held by Dr Mike Townend. Apologies to Tania and to Mike for this error.

Letter from the Dean of the Faculty of Travel Medicine

Dr Mike Jones FFTM RCPS(Glasg)

The outgoing Dean reflects

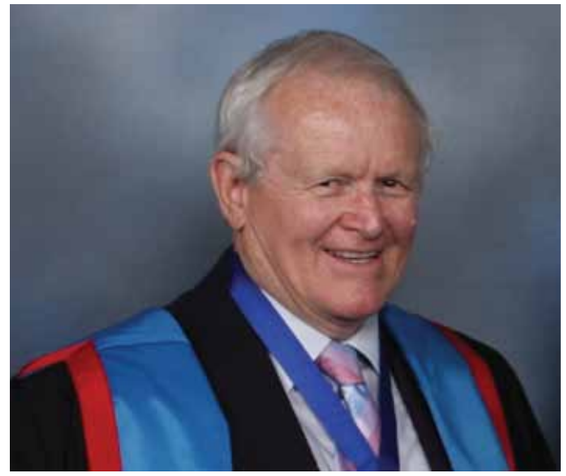
'Time flies', we always say as a period of work comes to an end, and it's always true as we look back. I began my term as Dean with some trepidation, following in the footsteps of two great predecessors—Dr Eric Walker, the founding Dean (2006-2009), and Professor Peter Chiodini (2009-2012). So what has my role involved?

First, it has meant chairing the Faculty Executive Board. Over the last three years we've had a consistently fine team, committed to improving education and standards in travel medicine, which has gradually evolved as elected terms ended and new ones began. I am a democrat and believe in strong collective leadership and responsibility, and it has been a real privilege to work with the Executive Board. Among our achievements:

- We have produced the **Health of Travellers report**, conceived by Professor Chiodini but reborn and published in September 2014 with an altered format and focus by a writing team chaired by Gp Capt Andy Green. This report is already having a positive effect on policy makers, including Scotland's Chief Medical Officer.
- Following a meeting with Hazel Hynd, the College's Head of Education, Training and Professional Development, we have appointed Jane Chiodini as the first Director of Education for the Faculty. Appointments to the Faculty Education Board will follow.
- The Diploma and Foundation courses in Travel Medicine are currently undergoing a process of accreditation by Glasgow Caledonian University. This means they will obtain formal recognition at university diploma and postgraduate certificate levels respectively and this will provide students with the wider formal recognition required to enable possible progression routes to other qualifications or learning programmes. For example, some Diploma students may wish to apply for further subsequent study or research with a university.
- The Diploma in Travel Medicine (DipTravMed) will be developed to incorporate Parts 1 and 2 of the Membership of the Faculty of Travel Medicine (MFTM) examination. Once finalised, this will mean that successful candidates will be eligible for Membership of the Faculty.
- We have launched a new Diploma in Expedition and Wilderness Medicine, which will be delivered by Dr Jon Dallimore and James Moore. Running two Diploma courses in tandem will have a symbiotic benefit for each course.

My second task as Dean has been representing the Faculty at College committees including the Executive Board, College Council and Fellowship Committee. I've also participated on the Charitable Committee, which considers grants to deserving causes.

My third task has been representing the Faculty internationally, funded, with one recent exception, from sources other than the College. This has taken me to major conferences in Rio de Janeiro, Pondicherry in India, Maastricht, Quebec and Durban. In February 2015, we held the



first travel medicine conference in the gulf region at Muscat, Oman, and there is interest for another in Qatar. Just a few days before I demit office I will speak at a conference in Prague.

Over my three-year term we've had spectacularly good educational events and I pay particular tribute to Margaret Umeed, as Education Convenor, whose team has organised these. I was elected with a promise to pursue working relationships with the BGTHA, NaTHNaC, HPS and ISTM and we have done this, with joint conferences and broadly-based speaker panels representing these organisations. An excellent symposium in June extended our cooperation to MASTA.

Finally, I want to thank special people. Margaret Umeed has been an exemplary Board Secretary. Andy Green as Vice Dean and then Dean-elect has been a joy to work with—expect exciting times ahead as the Faculty develops in new ways. My thanks also to Sandra Grieve and Sharon Graham as Emporiatrics co-editors, and to Ann McDonald and Clare Henderson as Course Managers.

I am also grateful to the College for the support of two successive Presidents, the Vice Presidents, Chief Operating Officer, heads of units and all their staff.

We really are hugely privileged to be a Faculty located in this Royal College, the first ever to embrace a Faculty that includes nurses and pharmacists as well as doctors, with all three professions participating as elected office bearers. At some point, I expect a future Dean will also become a College Vice President and I look forward to that day.

Dr Mike Jones
FFTM RCPS(Glasg)

Taking up this role in October, the new Dean, Andy Green, will outline his vision for the Faculty in our next issue.

Bulletin Board

Share the spotlight

Advertising (for example, in conference bags) is an ideal way to reach health professionals. Companies, including those delivering travel health training and education, can seize that opportunity by sponsoring FTM symposia, study days and conferences.

Details from: **jennifer.crozier@rcpsg.ac.uk**

The RCN—100 years on

The Royal College of Nursing UK has announced a series of projects, publications and events to celebrate its centenary in 2016 at: **www.rcn.org.uk/newsevents/rcn_centenary/projects**

See a timeline of key dates in its history at: **www.rcn.org.uk/aboutus/our_history**

What's new from WHO

- The WHO/UNICEF Joint Monitoring Program, established in 1990, has published its findings on the challenges faced by half the world's population living without safe drinking water and basic sanitation: **www.wssinfo.org/fileadmin/user_upload/resources/JMP-Update-report-2015_English.pdf**
- The Global Advisory Committee on Vaccine Safety met in the summer to examine WHO's record in monitoring dissemination of vaccine safety information and review data related to the safety of novel vaccines against Ebola virus and dengue.
- Immunisation data published by WHO and UNICEF shows that 129 countries now achieve at least 90% coverage of children with the required three doses of diphtheria-tetanus-pertussis containing vaccines (DTP3) – twice as many as in 2000. Central African Republic, Chad, Equatorial Guinea, Somalia, South Sudan and Syria achieved less than 50% coverage. **http://who.int/immunization/newsroom/press/immunization_coverage_july_2015/en/**
- WHO's Global Vaccine Action Plan 2011-2020 is at: **http://who.int/immunization/global_vaccine_action_plan/en/**

MenACWY immunisation update

All young people aged 14-18, regardless of whether they are in education, have been added to the UK national vaccination programme for quadrivalent Men ACWY vaccine. This replaces the Men C vaccine for young school pupils and first time university entrants under 25 years who did not receive the vaccine in school.

Babies born from 1 July 2015 will now receive meningococcal group B (Men B) vaccine alongside the existing routine childhood vaccinations at 2, 4 and 12-13 months. This is the first national and publicly-funded Men B immunisation programme in the world using Bexsero®.

Information and links at: **www.gov.uk/government/uploads/system/uploads/attachment_data/file/443262/PHE_9402_VU230_June_2015_11_web.pdf**

Child protection measures for FGM

Operation Limelight, a collaboration between the Metropolitan Police and UK Border Force, is targeting inbound and outbound flights for 'countries of prevalence' to protect vulnerable passengers from female genital mutilation. Heathrow's Safeguarding and Trafficking Network has around 95 officers across all terminals. A consultation on new FGM statutory guidance for frontline professionals, including details on mandatory reporting, ended on 30 September with publication expected by the end of 2015.

Health Regulations for Hajj and Umra seasons 2015

As the 2015 Hajj season comes to a close, healthcare professionals are reminded to be alert to ill travellers returning from Saudi Arabia.

WHO: Weekly Epidemiological Record No. 31, 2015, 90, 381–392 31 July.

http://www.who.int/wer/2015/wer9031.pdf?ua=1

NaTHNaC: **https://www.nathnac.org/pro/factsheets/Hajj_Umrah.htm**

TRAVAX: **http://www.travax.nhs.uk/news/news-record-page.aspx?id=21048**

Updated UK Malaria Guidelines

The 2015 UK Malaria Guidelines have been published and are available at: **https://www.gov.uk/government/publications/malaria-prevention-guidelines-for-travellers-from-the-uk**

New edition of Yellow Book

The latest CDC Health Information for International Travel is now available online at: **wwwnc.cdc.gov/travel/page/yellowbook-home**

Print versions can be ordered and a mobile app is coming soon.

From the UK Foreign and Commonwealth Office

- Let the Games begin: this FCO campaign advises British fans travelling to the 2016 Olympic and Paralympic Games in Rio de Janeiro to visit their 'Stay Ahead of the Games' website at: **www.gov.uk/government/news/stay-ahead-of-the-games-rio-2016**
- Know Before You Go: the British Embassy produced a handy postcard guide with travel tips for British nationals in Qatar in advance of their summer holidays. General KBYG information is at: **www.gov.uk/knowbeforeyougo**

Best wishes to Ann McDonald, who retired from the Royal College of Physicians and Surgeons of Glasgow in June. We will miss her support and wisdom as Course Manager for the Faculty of Travel Medicine and a frequent contributor to Emporiatrics.

Nepal earthquake sends aftershocks through the health system

A report by Dr Prativa Pandey, Medical Director at CIWEC Hospital and Travel Medicine Center in Kathmandu.

Nepal was hit by an earthquake of 7.8 Richter scale magnitude on 25 April, followed by a second of 7.3 on 12 May earlier this year. It killed more than 9,000 people and injured more than 23,000.

In remote mountainous districts, health facilities collapsed, leading to loss of physical infrastructure and damage to supplies and medicines. Some 456 health facilities were destroyed and a further 690 were partially damaged, with health care delivery being provided through makeshift tents and camps.

The earthquake triggered an avalanche on Mt Everest that killed 18 people and injured 65. More than 30 climbing teams with as many as a thousand people were on Everest at the time. In the Langtang National Park, a large avalanche of snow, ice and rocks swept through the entire village of Langtang, wiping out everything in its path and killing 128 people, both foreigners and Nepalis. Another 200 were missing.

Assessing the damage

Crush and fall injuries were by far the largest number of cases seen in hospitals immediately after the earthquake. Infectious diseases were not prevalent in the beginning, but later infections were reported in surgical wounds.

Within a week or two almost all foreigners, whether sick or healthy, were evacuated out of Nepal by their insurance companies or their respective countries.

CIWEC Hospital and Travel Medicine Center was involved in taking care of injuries in the foreign and the Nepali populations from the zero hour. Right after the earthquake, our parking lot was converted into a triage area for patients with injuries. Over the next few days, we took care of many trekkers and guides from the Everest and Langtang areas, and treated multiple orthopaedic injuries, mainly with rib, pneumothorax and pelvic fractures.

While we excelled in providing acute care, physical rehabilitation of the injured and the heavy emotional toll on both children and adults were not adequately addressed in a timely manner.

Nepalis, whose homes were destroyed by the earthquake, have been living in temporary shelters and camps. The threat of infectious disease is great in these places where people are living in crowded and less hygienic conditions. In many communities, the water supply has been disrupted or the natural source dried up, and toilets have been destroyed in the earthquake, further compromising sanitation.

Temporary camp in Nepal

Cholera

Cases of cholera have surfaced in Kathmandu at the Sukraraj Tropical and Infectious Disease Hospital (STIDH) at Teku and in the Kanti Children's Hospital, and there was a small outbreak of cholera in the central jail. No deaths have been recorded and the disease so far is contained.

Cholera is endemic in Kathmandu with cases seen every monsoon and epidemics occurring from time to time in both Kathmandu and Western Nepal. In the foreigner population, studied with detailed microbiologic and molecular testing at CIWEC every 10 years, cholera has not been found to be a pathogen of acute diarrhoea. This indicates that you do not get cholera if, as most foreigners are, you are careful with what you drink.

Asia Pacific Travel Health Conference

A lot of travel related illness occurs in Nepal, ranging from altitude illness to gastrointestinal infections. Bearing this in mind, the 11th Asia Pacific Travel Health Conference of the Asia Pacific Travel Health Society **(www.apthc2016.com)** is being held in Kathmandu next March at the historical Yak and Yeti Hotel.

Along with the usual topics, there will be a pre-conference workshop focusing on altitude illness, a certifying examination of the International Society of Travel Medicine and post-conference organised treks. Along with world-class speakers and plenty of opportunities to get together, delegates are invited to see the monuments that survived the earthquake and have fun in this adventure travel destination.

Find out more about the CIWEC Clinic at: **www.youtube.com/watch?v=_BAqxbtYPjw**

CIWEC Hospital and Travel Medicine Centre, Kathmandu

Senior travellers:
The importance of travel medicine in domestic travel

As more older people use their extra time and money to travel, they may not be aware of the real challenges they face in some of those quiet, away-from-it-all destinations. Irmgard L Bauer FFTM RCPS(Glasg) and Dr Peter Reed, studied senior travellers to Lord Howe Island –a 'paradise on earth' that counts as 'domestic' travel to Australians, but with no mobile phones, one policeman, six miles of paved road and limited access to the outside world, it's a long way from home if something goes wrong. Their insights apply to pre-travel consultations the world over.

World Heritage-listed Lord Howe Island is less than two hours' flight from Brisbane or Sydney off the east coast of Australia. Its small size (56 km^2), spectacular geography and highly diverse flora and fauna provide unparalleled experiences of natural beauty on the world's southern-most tropical island.

Home to about 350 local residents and 150 itinerant workers, a maximum of 400 tourists are accepted at any one time though there are many fewer during the low season (May to September), the time preferred by senior travellers. There is no mobile phone coverage and internet access is minimal. Holiday activities concentrate on nature-based pursuits such as walking, trekking or bird-watching, including conservation 'voluntourism', and water-based activities such as boating, fishing, snorkelling or scuba-diving.

The island particularly appeals to senior travellers, looking for a relaxed pace and lifestyle similar to mainland Australia decades ago. However, these very features can also pose serious challenges.

Transport

Most of the 11km of sealed roads are without footpaths or kerbs, with island foliage often growing right up to the edge. There are no traffic lights or roundabouts and street lighting is minimal. The speed limit is 25km/hr and drivers tend to be very aware of pedestrians and cyclists. Many roads are fairly level, but some areas are very steep. Most transport is by walking or bicycle, with a few small cars and electric golf carts for hire.

Tracks

Walking tracks vary from easy to difficult. Many guides recommend Transit Hill as a short, easy walk with 360° views—an excellent way to assess one's ability. Others are more hazardous—on exposed cliffs and rope-assisted climbs. Information on track conditions is readily available. Mt Gower, at 875m, is the tallest mountain on the island. In 2012, world renowned natural history filmmaker Sir David Attenborough, then 86, climbed Mt Gower, but as he reported, "it did my knees in."

Medical facilities

On weekday mornings, Gower Wilson Memorial Hospital runs a clinic with a doctor, nurse and receptionist. A small dispensary is available weekdays. There is no pharmacy, but over-the-counter medications are available from local shops. There are basic x-ray facilities and an emergency room with resuscitation equipment.

"Sir David Attenborough, then 86, climbed Mt Gower, but as he reported, 'it did my knees in'."

Remoteness

It's not so much its distance from the mainland (approximately 600 km) as the weather-dependent low-volume access. Most tourists arrive by air in a 36-seater plane, but the surrounding terrain prevents landing in some weather conditions. Weather also restricts resources with supply ships unable to dock. Cancelled flights are not uncommon with no mail, food, medical supplies or sick tourists able to get on or off the island. Understanding this is key to a rewarding stay on Lord Howe Island.

Methodology

First, this small study describes the location from a tourist's point of view through participant and non-participant observation over one week in May 2012, the low season with mostly senior visitors. Irmgard Bauer joined in island activities and had informal conversations with visitors, and hospital and council staff.

Second, to ascertain the use of the medical facilities by senior travellers (as precise statistics are not kept) we produced a summarised overview based on Peter Reed's locum work experience from 2011 to 2013, with permission from the Lord Howe Island Board.

Seniors' activities and potential health threats

Walking is the main form of transport, either purposefully, strolling or trekking. Walking tracks outside the settlement are well sign posted and maintained but hazards do exist, for example, mutton bird holes (the size of a foot), roots and rock. Steep timber steps can be difficult from a mobility or cardiovascular point. Tracks can be slippery when wet. Calling for help is difficult without mobile phone coverage.

A popular water-based activity for this age group is an environmentalist guided, glass bottom boat trip on the lagoon. The water is smooth but getting on and off can be difficult. Also popular is a cruise around the island, which can encounter rough water and cold wind, triggering joint and muscle pain.

Use of medical facilities

By far most common causes of curtailing or prematurely ending a senior's stay are falls and acute medical illness. The most common reasons for a senior traveller to seek medical attention are minor injuries, minor infections and medication issues; most can be minimised through preparation and prudent behaviour.

Pre-trip preparation

Given the remoteness and resource limitations, travellers should be as self-sufficient as possible, with a small first aid kit including simple analgesics, plasters, motion sickness tablets, dressings and tweezers. Small quantities are sufficient as long as travellers restock any spent item from the local shop. A visit to the GP or a travel health professional is wise. Travellers should pack enough medication, contact lens solution, dental and/or denture care, or any other regularly used product to last for the trip and at least 4-5 days more in case of flight delays etc. For long stay travellers, GPs should arrange an extra supply of medication to cover this period. Visitors travelling with needles (e.g. for insulin injections) need to bring spares and also a sharps disposal container for storage and transport. Weight restrictions on flights occasionally mean baggage may arrive with the next flight so medication covering a few days should be packed in hand luggage and transport of needles confirmed with the airline.

The same principles apply to any aids or appliances, such as walking aids, hearing aids, dentures, breathing apparatus, glasses and so on. Long-stay travellers who require monitoring can be seen within a couple of days' notice, but blood tests are only sent off once a week, depending on weather.

Dr Irmgard Bauer is a senior lecturer in the Division of Tropical Health and Medicine at James Cook University, Queensland. Dr Peter Reed practices at the Pine Ridge Medical Centre in Scoresby, Victoria.

Prevention on the island

Without repeating earlier notes on injury prevention, let common-sense prevail. Unwell travellers should seek medical attention early rather than wait until the symptoms are more difficult to treat. A simple cut in a sub-tropical environment can lead to further problems if not treated promptly.

General recommendations

A proportion of senior travellers will need to consult the medical facilities at least once during their stay, but prudent preparations can reduce this likelihood. It's important to pack smart and light, but prioritise items essential for health and wellbeing, such as medications, aids, walking poles, appropriate clothing and footwear, hat and sun screen. Get age-appropriate travel insurance. Avoid over-excessive sun and heat, dehydration, excessive alcohol consumption and unusually strenuous activities. For some travellers, if frail or with memory difficulties, group travel may be a safer option.

Travel medicine usually focuses on international destinations yet domestic travel can pose a certain set of risks. As senior Australians travelling to Lord Howe Island may discover, prudent preparation and suitable behaviour on location are just as necessary, despite the perceived security of travel in one's own country.

GPs might consider leaving appropriate information in their waiting rooms to remind older patients to mention domestic travel during a consultation. To give high quality pre- and post-travel care, travel health advisers may also need to inform themselves about domestic destinations that are popular with older people.

For Tables and References please contact the Editor:
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TRAVELLERS' DIARRHOEA:

It's time to give up old habits of prescribing antibiotics

A challenge from Anu Kantele FFTM RCPS(Glasg), Tinja Lääveri and Lars Rombo FFTM RCPS(Glasg)

Travellers' diarrhoea (TD) remains the most common disease encountered by visitors to areas with poor standards of hygiene. Some recommendations still consider antibiotics to be the 'principal element' in the treatment of TD while others are more cautious. As new data emerge, a look into pros and cons is warranted.

The pros

Numerous studies show antibiotic treatment to be efficacious against TD. This has been proven with several drugs such as fluoroquinolones, macrolides and rifaximin. Most travellers wish to recover as soon as possible and, indeed, taking antibiotics shortens the course of the disease. According to a Cochrane meta-analysis on TD, two-thirds of those with antibiotic treatment and half of those without it are symptomless at 72 hours.

The cons

Adverse effects of antimicrobials are often mild yet more common than generally believed. According to the Cochrane meta-analysis, every sixth patient treated with antibiotics experiences adverse effects. Paradoxically, in 5-25% of patients, antibiotics may cause antibiotic associated diarrhoea (AAD), among them Clostridium difficile diarrhoea. This is in fact one of the effects antibiotics have on the intestinal microbes. Even a brief course may upset the balance of the microbiota for a long time—up to two years after treatment. By killing members of the intestinal microbiota, the drugs also pave the way for newcomers which include strains resistant to antibiotics.

Recently, both TD per se and its treatment with antibiotics have been shown to predispose travellers to contracting resistant intestinal bacteria while travelling. The risk is greater for visitors to countries with poor standards of hygiene and weak or non-existent antimicrobial policy. The risk is exemplified by our recent investigation in which 67% of travellers had TD. ESBL-PE was contracted by 11% of healthy travellers (TD−AB−), 21% of those with TD not taking antimicrobials (TD+AB−) and 37% with TD taking antimicrobials (TD+AB+). The respective figures for the region with highest risk, South Asia, were 25%, 49% and 80%. Breath-taking numbers!

The consequence of colonization with resistant bacteria has three levels of significance: individual, societal and global. The individual's risk of contracting a clinical infection by the strain is relatively small, yet the clinical picture may range from mild cystitis to life threatening conditions.

As for the societal level, the strains may spread to household members and other contacts and, eventually, to local hospitals, leading to increasing costs for healthcare services.

Finally, the global aspect refers to travellers acting as transporters of resistant bacteria across the globe, thus contributing significantly to the increase in antimicrobial resistance worldwide.

The challenge

Antibiotic resistance is considered to be a serious threat for modern medicine. Therefore, the World Health Organization calls on all levels of society to act against this growing problem. One of the key tactics is to decrease the use of unnecessary antibiotics.

Treatment of TD provides a perfect target for revising prescription habits. TD is usually a mild or moderate disease which resolves spontaneously. Travel medicine practitioners now have an opportunity to serve as key players in preventing the spread of the bacteria worldwide by educating both their fellow clinicians and their clients in cautioning antibiotic use for TD.

This is part of the larger entity: if we as healthcare professionals fail to take seriously the challenge of restricting antibiotic use now, the next generation of clinicians may not have effective antibiotics as an option to treat even those whose life could be saved.

New UK guidance

The National Institute for Health and Care Excellence (NICE) has released its first guidance on tackling antimicrobial resistance. Developed by the Medicines and Prescribing Centre at NICE it's aimed at health professionals. Information is also available to the general public.

Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use is at:
www.nice.org.uk/guidance/ng15

IN FOCUS:

Dipti Patel FFTM RCPS(Glasg)

By any measure, Dr Dipti Patel leads a busy life. In a job share with Vanessa Field, she is Joint Director of the National Travel Health Network and Centre (NaTHNaC), leading a multidisciplinary team that advises and helps set standards for travel health practitioners in the UK. She is also Consultant Occupational Health Physician with the Foreign and Commonwealth Office (FCO) where she provides occupational and travel medicine advice for staff working or travelling overseas. Dr Patel was on the original shadow board when the Faculty of Travel Medicine was formed and remains active in its work.

Dr Dipti Patel

When did you first become interested in travel?

Very early! My family lived in Nairobi until I was four and we moved to London. But long before that, living in Kenya, my mother wanted at least one of her children to be born in India, so she went to Mumbai for my birth. I've actually been travelling from the age of six weeks.

Did you always want to be a doctor?

At school I wanted to be a chemical engineer yet when it came to filling in the application for university, I changed to medicine. I'm not sure why, but in retrospect I know it was the right choice. I studied at St George's Medical School in London.

How did you get into travel medicine?

During my training I worked at an inner city hospital with a high migrant population so I had experienced some aspects of tropical medicine. Later, once I'd trained to be a GP, I saw an FCO ad looking for a medical adviser, and that was what consolidated my interest in travel medicine. At the FCO, for the first time I felt I had the luxury of time to practice medicine thoroughly – to do preventative rather than just reactive medicine.

From there I trained as a specialist registrar in occupational medicine, supporting primarily staff and students at Guy's and St Thomas' NHS Hospitals Trust. This included supervising a special study module in travel medicine. Then I was lucky enough to complete my specialist training while working at the BBC, my first consultant post.

What did you do at the BBC?

The BBC had a well established occupational health department, but their travel health services were not as well established so it was a fascinating period. A key responsibility was working with the news staff, and our correspondents were going into some very challenging environments, especially during the second Gulf conflict. I also worked with the natural history unit in Bristol who made programmes like the Big Cat Diary, and with BBC Films, supporting big overseas productions like Shooting Dogs, which was filmed in Rwanda.

When did you begin to move into more strategic roles?

I became Director of Clinical Services at MASTA (Medical Advisory Service for Travellers Abroad), which required me to understand complex issues in travellers of all ages, and also was a Non-Executive Director with Health Protection Agency (HPA).

By the time I returned to the FCO, I felt able to make a real difference in strategic areas. Examples of some of the work I do there include looking at the FCO's approach to malaria prevention in staff and dependants, or the potential health effects of air pollution for staff and dependants places such as Beijing or New Delhi. The job at NaTHNaC was the next obvious step for me, and I was happy to job share because I didn't want to give up my work at the FCO. Both positions complement each other.

What is a typical day at NaTHNaC?

No such thing! I may be giving a doctor's input on our advice line – we average some 8,000 calls a year from health professionals, or dealing with yellow fever centre issues. I spend time teaching, liaising with our partner organisations and listening to our stakeholders to be sure we are meeting their expectations.

I've been leading on the development of our new website, and as a team we are always looking for ways to make the services we provide our users better, for example, after the success of our online yellow fever training, we are developing similar training in risk assessment.

Most of all I like to get involved in new ideas that will help improve travel health in the UK. A large part of my job is engaging with users and responding to what they need. That's what makes every day challenging – and rewarding.

New NaTHNaC website launched

Check out this user-friendly and valuable resource for health professionals
http://nathnac.net/

Ebola: A personal journey

Dr Kitty Smith FFTM RCPS(Glasg) was keen to help in West Africa during the recent Ebola outbreak, but as medical lead for the travel medicine and international health team at Health Protection Scotland, she had her hands full preparing for the possibility of imported cases at home.* She finally got her chance in May 2015, covering for Janet Scott, clinical lead at the Liverpool University Ebola Convalescent Plasma (EbolaCP) Study in Sierra Leona. Not everybody's idea of a holiday, but a terrific story!

I arrived in Sierra Leone at the start of the rainy season and in the middle of a storm, which made the boat ride from Lunga Airport rather exciting. I was met at Freetown harbour by Mohamed, who became a very important person in my life for the next four weeks, acting as driver, fixer, interpreter and provider of sensible advice and information.

At Freetown the outbreak was not over, but the number of new cases of Ebola virus disease (EVD) was declining, the curfew had been lifted and people were once more attending schools, shopping and socialising. There was still a 'no touch' rule – no handshaking, hugging or kissing. Hand-washing was required outside public buildings (including supermarkets) and temperatures were taken frequently using no-touch thermometers. These were often inaccurate – my temperature was recorded as 33° C on one occasion and 39° C on another, both without comment!

Ebola Convalescent Plasma Treatment

Good supportive care can reduce mortality in EVD significantly, but at present there is no established specific treatment. A number of experimental treatments have been made available on compassionate grounds or as part of studies since the outbreak began, including convalescent plasma.

Convalescent plasma (CP) has been used to treat viral haemorrhagic fevers since the 1970s but safety and efficacy in acute EVD have not been established. As a treatment, CP has advantages over others in resource-poor settings: it is relatively inexpensive once the apheresis machine is supplied, donors are likely to be available in outbreaks and plasma can be stored for long periods, enabling stockpiling.

The Ebola CP Study

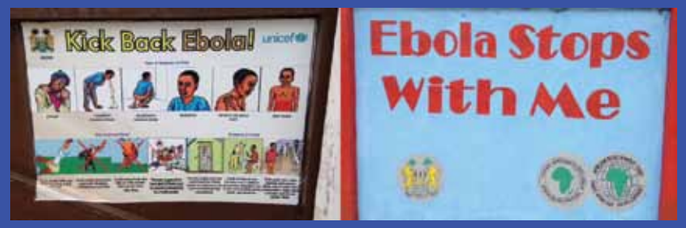
Studies on the use of CP as treatment for EVD are prioritised by the World Health Organization in the current outbreak and the Ebola CP Study is recognised by WHO and the Sierra Leone Ministry of Health as part of the Ebola Emergency Response.

Many people, institutions and organisations are involved in or partnered with the study. Ebola survivors are assessed at the 34th Military Hospital, Freetown, as possible donors and study participants. Plasma is collected and stored at the Blood Bank, Connaught Hospital. The study is audited and monitored by Clinical RM,a US-based contract research organisation.

The most important people in the EbolaCP Study are the donors themselves. As Ebola survivors, they have experienced terrible fear, debilitating illness, long-term health problems, loss of family and friends, loss of livelihood and stigma. They willingly gave their plasma in the hope that they may save the lives of others, but they were more reticent about providing blood samples for immunological analysis.

Blood has immense significance in Sierra Leone, as in many African countries. There are strong taboos, for example, about mixing blood from more than one person. This was a major challenge to the CP study team and required sensitive handling and relationship building with the donor organisations.

Freetown from above



Ebola road sign and street poster, Freetown

My role in the Ebola CP Study

I was involved in building relationships, liaising with the blood bank, MH34 and Clinical RM, preparing sites for monitoring visits, auditing case report forms and stored specimens in the Blood Bank, compiling lists of donors, helping to plan the next phase of the trial, liaising with representatives from Ebola survivor groups, and providing GCP training and input into updating the protocol.

Liverpool University has also been providing healthcare for Ebola survivors who frequently have chronic health problems including a progressive uveitis which can result in loss of vision. I saw three patients in the MH34 clinic with total visual loss in one eye. I liaised with NGOs, WHO and the Department for International Development to discuss the provision of care for survivors, including projects to raise awareness of eye disease, thus diagnose and treat before visual loss occurs.

I was privileged to be part of the international effort to provide acute Ebola patients with a possible treatment and help address the health issues of Ebola survivors. A treatment that is both clinically and cost effective would change the way we manage outbreaks in the future.

*In the event, it was lucky she did since Scotland had the only case diagnosed in the UK- happily, now recovered.

Dr Sesay, doctor at the MH34 survivors clinic

Freetown market

Etu military hospital MH34, Freetown

EBOLA ROUNDUP

Ebola impacts on routine vaccinations
As malaria treatment and immunisation for measles, pertussis and other vaccine-preventable diseases were neglected during the Ebola outbreak, WHO is calling for urgent intensification of routine services in all areas and for mass measles vaccination campaigns in areas free of Ebola transmission.

Guidance is at:
http://who.int/csr/resources/publications/ebola/immunization.pdf?ua=1

One year on from the start of the Ebola outbreak
WHO updated the Ebola virus disease outbreak information in July 2015.
http://www.who.int/csr/disease/ebola/en/

The road to zero is CDC's response to the West African Ebola epidemic:
www.cdc.gov/about/ebola/index.html

Ebola vaccine on the horizon
An interim analysis of the Guinea Phase III efficacy vaccine trial shows that VSV-EBOV, developed by the Public Health Agency of Canada, is highly effective against Ebola. More evidence is needed on its capacity to protect populations through "herd immunity". The trial continues. See: **www.who.int/mediacentre/news/releases/2015/effective-ebola-vaccine/en/**

A TRAVELLER'S TALE

Canada and the wild, wild west

While visiting Quebec for CISTM14, Carolyn Driver FFTM RCPS(Glasg) decided to tack on a holiday that would take in some of the most spectacular scenery in the world.

Carolyn at Lake Peyto

This stunning landmark was named after Wild Bill' Peyto (1869-1943), an English traveller who settled there and became a warden at Banff National Park

We arrived in the lovely city of Quebec via Toronto and my husband Peter enjoyed exploring the old town while I was busy with CISTM14. As long as we were 'in the neighbourhood', we reasoned, we might see a bit more of Canada—a plan that ended up taking us all the way to the Pacific coast.

We first flew to Calgary and picked up a hire car – no economy compact for us after my 'petrol head' husband spotted a Ford Mustang Coupe in the car park. We made Lake Louise our base for exploring the Rockies and soon ran out of superlatives as we drove along the Icefield Parkway. In early June we enjoyed mostly warm weather, but there was still plenty of snow on the mountains. Lake Peyto's fabulous colour comes from glacial rock flour brought down by the melting snow.

Our photos of wildlife were shot from the safety of the car after witnessing the angst of a park warden when a grizzly bear crossed the road about 50 metres in front of us - other tourists had got out of their cars to get pictures!

My travel health brain kicked in again at Johnston Canyon which contains an incredibly strong force of water and magnificent falls along its walking route. Despite a clear footpath and safety signs at regular intervals, just two days before a young hiker drowned when he climbed over the railings to 'cool off'.

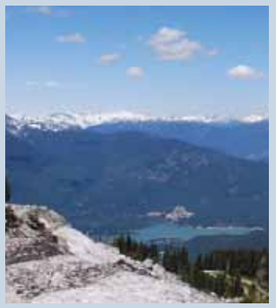
We headed for Vancouver via a scenic route taking in Canada's wine-growing region – tasting was essential, but what a shame my name wasn't on the car hire agreement!. In Vancouver I had to prize the Mustang away from Peter and let relatives be our local guides on a tour of the beautiful city of Vancouver, the famous ski resort of Whistler, then over to their home on Vancouver Island.

We enjoyed every minute of our trip—the scenery is breathtaking and the people are lovely. Highly recommended!

Carolyn Driver is an independent travel health and immunisation specialist nurse.

Trauma-related deaths in travellers are just as likely in industrialised countries as in the poorer parts of the world

Driving along the Bow Valley Parkway we sighted this black bear grazing at the side of the road



Whistler is a year-round magnet for adventure travellers

The use of PGDs for private travel vaccines in England

Jane Chiodini FFTM RCPS(Glasg)

Thanks to the Editor of Practice Nurse for permission to publish this article.

Legislation passed in 2000 brought Patient Group Directions (PGDs) and Patient Specific Directions (PSDs) into existence and at that time we were administering most travel vaccines under PGDs. However, during 2007-2008 it became clear that the only travel vaccines that could be administered under a PGD in an NHS setting were the NHS vaccines. These were and still are hepatitis A, typhoid, polio, cholera and *any* vaccine that has one of these components within it. For example, Revaxis is combined tetanus, polio and diphtheria, so it comes under NHS provision for travel purposes in an NHS setting.

The Human Medicines Regulations 2012 came into force on 14 August 2012 and it would appear that within the statutory document, an exemption was made for the provision of prescribing in private practice. The Care Quality Commission (CQC) in their GP Myth buster 19: PGDs / PSDs, published in December 2014 states:

'A GP practice can, in law, develop their own PGDs for use in their private practice (non NHS work), for example for the administration of travel vaccines (such as yellow fever, rabies and Japanese B Encephalitis).When doing this they will need to make sure that they involve the appropriate people in the development of the PGD, and follow the information in the sections also included in the myth buster about writing operating information contained and labelling.'

This information regarding the changes from 2012 does not appear to have been known by the travel medicine community and the legislation from the Human Medicines Regulations 2012 only applies to England. However, this would have significant impact on the administration of private travel vaccines in an NHS GP surgery.

At the current time, we are operating under a PSD or a prescription if a private travel vaccine is needed (e.g. yellow fever, rabies, Japanese encephalitis and tick-borne encephalitis). If following risk assessment it is decided the traveller needs such vaccines, they need prescribing before administration. This has made the smooth running of the consultation challenging, with some getting the prescription signed after the event, which is incorrect and illegal.

Public Health England has published immunisation PGD templates to support national immunisation programmes which were developed, ratified and signed by Public Health England's national immunisation team at:**www.gov.uk/government/collections/immunisation-patient-group-direction-pgd** . Currently PGDs for the NHS travel vaccines are usually provided by the Medicines Management Team within a Clinical Commissioning Group.

In July 2015 the BMA published updated guidance on PGDs and PSDs at: **http://bma.org.uk/practical-support-at-work/gp-practices/service-provision/prescribing** This document includes

'important information that the MHRA has taken the view that English GP surgeries registered with the Care Quality Commission for relevant regulated activities (for example, treatment of disease, disorder or injury) can develop and sign off their own PGDs for any wholly private services they offer. GPs can sign off a PGD for a private service or private travel clinic.'

Of course the GP would need to follow legislation governing authorisation of PGDs in a private setting. A pharmacist would need to be involved in the development of the PGD and it would seem sensible to have a healthcare professional who is highly experienced and qualified in the practice of travel medicine to be involved in the development of such a document.

In the resources section of the information regarding PGDs on the NICE website, a PGD template has been provided and it would again seem sensible to follow this format when developing a private vaccine PGD. **www.nice.org.uk/guidance/mpg2/resources**

This news will hopefully change the practice of travel health in a GP setting for the provision of private vaccines, not only making it far safer, but also improving standards for the many practice nurses who provide excellent travel health care in England.

*See:**www.cqc.org.uk/content/gp-mythbuster-19-patient-group-directions-pgds-patient-specific-directions-psds**

Further links to information can be accessed at: **www.janechiodini.co.uk/news/faqs/faq-no-1/**

Thanks to Elaine Biscoe (National Practice Nursing Adviser) and Brian Brown (National Medicines Manager) at the CQC for their help in initially informing me of these changes.

NaTHNaC published a Clinical Update in August 2015.PGD: use in NHS travel services **www.nathnac.org/pro/clinical_updates/pgd_travel_140815.htm**

IN REVIEW...

Conferences

NECTM6: 6th Northern European Conference on Travel Medicine

An update from Dr Tania John, AFTM RCPS(Glasg), Chair of NECTM6 Local Organising Committee

Registration for NECTM6 is now open. Indeed, our first registrants were from the other side of the globe (Australia) so the event looks set to be truly international. We are pleased to have secured the prestigious Queen Elizabeth II Centre, immediately opposite Westminster Abbey in the heart of London, as the conference venue.

The scientific programme will see strong global health and one health themes alongside traditional travel medicine content. New for this NECTM will be more informal 'breakfast symposia', and workshop series' in expedition medicine and international medical transportation, run as day courses.

The conference dinner will take place aboard either The Symphony or The Harmony where you can enjoy an evening river cruise on the Thames, but be quick: it will be popular and places are limited. A variety of other social events are being planned.

The informal "Nurses Welcome", provides an opportunity for nurses from around the world to meet and network. Preferential delegate rates are available for NECTM Partner members and accreditation is being sought.

We are delighted to have teamed up with the Global Alliance for Rabies Control (GARC) as our charity partner and will be entering teams in a number of fundraising sports events over the next year with further fundraising initiatives during the conference.

Do visit the website for further details, to register, and to get involved. And don't miss the blog!

Tania John, LOC

Information will be updated as it becomes available. **www.nectm.com**

To make a donation or sponsor Team NECTM6 go to:
www.justgiving.com/Team-NECTM6

The ISTM Certificate in Travel Health CTH® will take place during NECTM6 on 1 June in London. **http://www.istm.org/certificateofknowledge**

Coming soon...

13 November 2015

MASTA
Annual Study Day
Royal College of Physicians London
www.masta.org

2-5 March 2016

11th Asia Pacific Travel Health Conference
Wilderness and mountain medicine: Travel medicine where it happens
Yak and Yeti Hotel
Kathmandu Nepal
www.apthc2016.com

1-4 June 2016

6th Northern European Conference on Travel Medicine (NECTM6)
Queen Elizabeth II Conference Centre, London
www.nectm.com

28 September-1 October 2016

South African Society of Travel Medicine (SASTM) biennial Congress and ISTM 7th Regional Congress
Travel Health Africa – the boiling point?
Boardwalk Convention Centre
Nelson Mandela Bay, Port Elizabeth
www.sastm.org.za/Events/Details/15

14-18 May 2017

CISTM15
Barcelona, Spain
www.istm.org

Apps...

A Yellow Card smartphone app Introduced in 1964 in the wake of the Thalidomide disaster, the Yellow Card Scheme monitors the safety of UK medicines and acts as an early warning system for side-effects and adverse reactions.

Run by the Medicines and Healthcare products Regulatory Agency, the new smartphone app helps patients, carers and healthcare professionals report concerns directly to ensure the drugs are safe. Download from iTunes App Store for IOS:
https://itunes.apple.com/gb/app/yellow-card-mhra/id990237487?ls=1&mt=8

or Google Play for Android devices:
https://play.google.com/store/apps/details?id=uk.org.mhra.yellowcard&hl=en_GB

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In Memoriam

Sadly we announce that two stalwarts of travel medicine have recently passed away.

Hans Lobel, a co-founder of the International Society of Travel Medicine (ISTM) died aged 85 years on 11 September.

Robert Steffan's tribute to Hans can be found in the September edition of ISTM's Travel Medicine News

http://www.istm.org/Files/Documents/Activities/Publications/NewsShare/201509.pdf

Alan Magill, a Past President of the ISTM died suddenly on 19 September.

The current ISTM President's message to Members said "at the age of 61, Alan was at the prime of his life and the height of his career. His sudden death is a tragic loss to us in ISTM and ASTMH, to the malaria community and to global health at large."

Their loss will be felt by many in the travel medicine community and our sympathies go to their families and friends.

6TH NORTHERN EUROPEAN CONFERENCE ON TRAVEL MEDICINE

1ST — 4TH JUNE 2016
QUEEN ELIZABETH II CENTRE, LONDON

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NaTHNaC
Royal College of Nursing