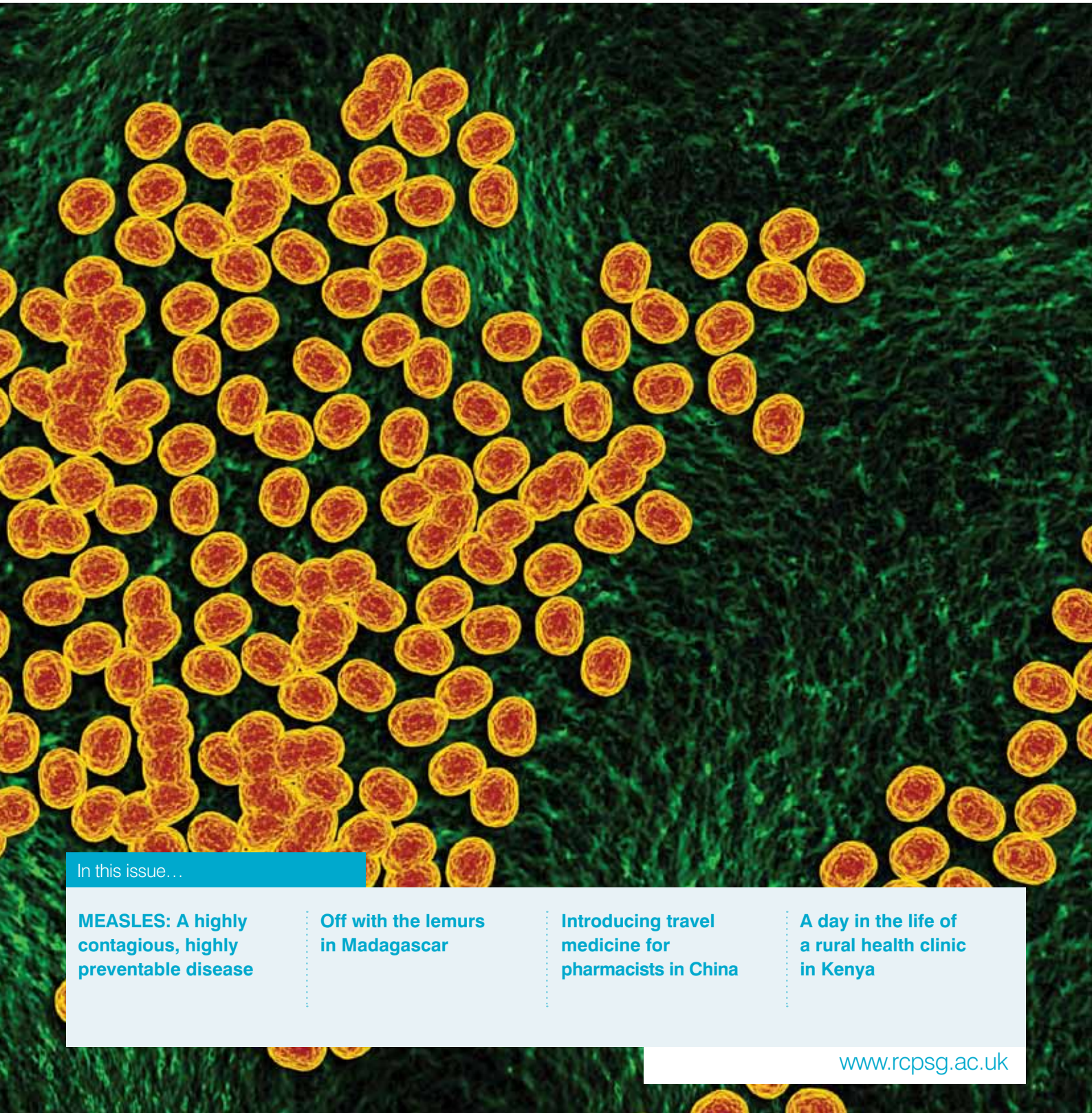
Spring/Summer 2014

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
TRAVEL MEDICINE

# emporiatrics

## News, views and reviews

from the Faculty of Travel Medicine



In this issue…



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## Regulars



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## Editorial


# Editorial

**em·por·i·at·rics (em-pōr'ē-at'riks),**

The specialty of travel medicine. [G. emporion, market, fr. emporos, traveller, merchant, + (technē) iatrikē, medical art]

In 1982 Dr Myron Schultz wrote*: "The new science of emporiatrics can point the way towards policies and programmes that will prevent needless suffering and so help increase international trade and tourism." Much has changed in 30 years but the sentiment remains. Still, our title has raised a few eyebrows and we'll be happy to consider an alternative that hasn't been (over)used elsewhere. Any suggestions?

By any name this edition is packed, proving proof (if needed) that TH practitioners certainly get out and about. On Page 4 we profile our Vice Dean, Group Captain Andy Green, whose RAF career puts a whole new slant on 'flying doctor'. Sharon Graham chases lemurs in Madagascar on Page 5 while, on Page 6, Jonathan Ross details how the oil and gas industry safeguards its global business travellers. On Page 8, Nicola Meredith looks at an outbreak of measles closer to home. Larry Goodyer gives an account of Chinese pharmaceutical services on Page 10, followed on Page 11 by Carole Tracey's insider tale of life as a ship's nurse. Starting on Page 12, we have two approaches to supporting healthcare in Africa – Ann MacDonald in an outreach programme for Kenyan villagers and Eric Walker, who stayed home but lived like an African villager to raise funds (you can still help). And finally, on Page 14 Jane Chiodini invites you to think about applying for the College's next Triennial Scholarship. As the current winner, she'll present her project at this June's Advancing Excellence in Healthcare triennial conference of the Royal College of Physicians and Surgeons of Glasgow, which includes a fabulous Faculty of Travel Medicine symposium (see Page 16). It's quite simply unmissible so … don't miss it! My thanks as always to our contributors. See you in Glasgow!

**Sandra Grieve**

*BMJ



# Letter from the Dean of the Faculty of Travel Medicine

**Dr Mike Jones FFTM RCPS(Glasg) on developing a long-term strategy with his 2020 vision for the Faculty.**

When I took over as Dean I wondered whether three years was too long a time in post. Now, almost 18 months into my term, time is flying by and there is much to do.

We warmly welcome four new Board members. Dr Jim Bond, an independent travel health specialist, and Jennifer Anderson, a London-based travel health specialist nurse, joined the Board in November and we also congratulate Jennifer on gaining her MFTM. In February Dr Pal Voltersvik from Bergen became our first member from outside the British Isles, fulfilling our commitment to honouring international leaders in travel medicine not only by making them Fellows, but by enabling them to be involved on the Board. Alan McDermid, a freelance journalist and former medical correspondent for the Herald newspaper, has joined us as lay representative.

We look forward to the international triennial conference of the Royal College of Physicians and Surgeons of Glasgow in June and our Faculty symposium in October. Thanks to Margaret Umeed as Education Convenor and her committee for superb symposia programmes.

We are developing a longer term strategy and hope to have achieved the following by 2020:

- **Recognition of Travel Medicine (TM) as a sub-speciality.** This will allow infectious diseases (ID) physicians to be appointed with TM as a special interest, solidifying the place of TM within ID training and making it more likely that nurses and pharmacists will be able to progress in careers after gaining the Dip Trav Med and MFTM.
- **A regular flow of new candidates for the MFTM examination.** As a first step towards that goal, a new joint MCQ examination will serve as Part 1 MFTM and the Dip Trav Med MCQ exam from 2015 onwards.
- **Appropriate levels of training for all who deliver travel health to the public.** We expect to launch a report under the title of The Health of Travellers over the next couple of months, and I am delighted that this brain child of the previous Dean, Professor Peter Chiodini, will soon be published. I thank the committee who undertook this extraordinarily hard work.
- **A new e-learning programme** to run alongside and integrate with the Dip Trav Med and Foundation courses to allow the acquisition of knowledge and skills for those who cannot travel to Glasgow for these courses. We expect to trial our first e-learning module in August.
- **Wider availability of FTM courses outside the UK.** The first Nordic Course ran in 2012 and another may run this year, demonstrating the potential for replicating this in other countries in Europe and beyond.

Welcome to the new Diplomates, Members and Fellows admitted to the Faculty of Travel Medicine of the Royal College of Physicians and Surgeons of Glasgow at the Admission Ceremony in June 2013. The successful candidates are shown with (front row, from left) Ann MacDonald, Travel Medicine Course Director; Dr Mike Jones, FTM Dean; Margaret Umeed, FTM Secretary; and Lorna Boyne, Honorary Clinical Registrar, Travel Medicine Course.

Diploma of Travel Medicine students should consider the benefits of becoming Associate Members of the Faculty. If you've any doubts, see: **http://rcp.sg/joinftm**

The next Admission Ceremony of the College will be on 18 June on the eve of the Advancing Excellence in Healthcare 2014 international triennial conference in Glasgow.

### A new post in the College in 2014

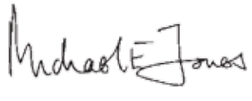
The FTM Board recently decided to appoint a Director of Education, bring us into line with other faculties in the College. This appointment will be for a three year term and the job description will appear soon on the College website.

In October I will retire from my post as an ID consultant, having by that time continued to work at the coalface of NHS practice for two of my three years as Dean. I am looking forward to devoting more time to the Faculty in my final year.

The election of the Dean-Elect looms in October, and I encourage all members to consider carefully whom to nominate. The new Dean will take office in October 2015.

Finally, my deep gratitude to Margaret Umeed and Andy Green as Board Secretary and Vice Dean respectively, whose support, wisdom and advice I value greatly.

**A range of awards and scholarships are now available. Find out more at http://rcp.sg/scholarships.**



# IN FOCUS: Group Captain Andy Green FFTM RCPS(Glasg) FRCPath RAF

You may know Andy Green in his role as Vice Dean of the Faculty of Travel Medicine, or through the work he's done to develop the CPD programme for travel medicine. We asked him to tell us a bit about his day job.

Andy represents the UK in various capacities within NATO and other international organisations.

**Historically, infectious diseases have taken out more soldiers in battle than bullets or bombs – a fact that has sent Group Captain Andy Green to some of the most remote outposts in the world. Over a distinguished military career, he has battled the most virulent microscopic enemies known to science – not to mention encountering a pregnant black widow spider who was just as aggressive.**

Andy is currently based in Birmingham, where he is Director of Infection Prevention and Control, Defence Consultant Adviser in Communicable Diseases and Consultant in Clinical Microbiology at the Ministry of Defence. He trained initially at St George's Hospital Medical School, London and joined the Royal Air Force in 1983. It was at the RAF Institute of Pathology and Tropical Medicine (RAF IPTM) that his interest in travel medicine took hold. "I was running a yellow fever clinic and, looking back, I was probably not doing it very well. We'd get referrals from all over for the yellow fever vaccine, and every single person would quiz me about what to do for malaria. This told me early on that you can't just give a jab and call it pre-travel advice. So that was my eye opening moment: I thought, 'This travel medicine is quite interesting'."

'Lesson: if grounded in a strange location, always follow the aircrew.'

He qualified as a specialist in clinical microbiology and was appointed Consultant Microbiologist at RAF IPTM in 1991. Around the same time the International Society of Travel Medicine (ISTM) started and he was hooked on the specialty from the beginning.

Over the next decade, having gained dual accreditation in communicable disease control, he was in the frontline of combating infectious diseases in the Armed Forces, particularly in outbreak management.

**Salmonella**

Take, for instance, a big outbreak of salmonella at an air base in the Falklands. "We had a huge catering facility and so a huge opportunity for getting things wrong. In a single sitting of a thousand people, there were 350 cases of salmonella - it really was a dodgy turkey curry." He'd hardly returned to the UK when he was called back again to the South Atlantic. "This time it was egg-related salmonella and I was singlehandedly responsible for disposing of 50,000 British eggs, which we pushed off the quay in Port Stanley. They'd taken six months to get there by ship, and having shown a clear link by epidemiological investigation there was no real alternative—although I might have thought twice about it, since it was only the Army being fed!"

And then there was the Tristar that was diverted in a storm to Dakar in Senegal. Over 100 of the 180 on board were hospitalised after a buffet salad served at the hotel where they stayed overnight. "We got 39 different pathogens from those people; normally we just find one. One of the interesting aspects of that outbreak was that none of the pilots was affected and neither were any blonde female passengers. It transpired that they had checked into another (upmarket) hotel, and eaten lobster instead of salad washed in sewage water. Lesson: if grounded in a strange location, always follow the aircrew."

Andy had the distinction of hoisting the 'Yellow Jack' quarantine flag on the Royal Yacht Britannia, in Cyprus to host a dinner for the 56 Commonwealth Heads of State attending a conference. It was salmonella again, but only the crew's kitchen was affected so a major international incident was averted. They avoided another by sailing out to anchor in international waters when the Cypriots decided to try to impound the Royal Yacht.

More recently a severe outbreak among our troops in Northern Afghanistan led the news bulletins at home and had everyone baffled till it was diagnosed a week later as norovirus. It's a common illness in the UK but potentially life threatening in that intensive operational zone where people are dehydrated and living in harsh conditions. "Again that's travel medicine: bugs don't read the textbooks so they never play by the rules. Back then I was giving daily briefings in Whitehall to Ministers wanting to know if this was a deliberate attack on our troops, and whether they would be held responsible for importing the disease into the UK. That was when I learnt the satisfaction gained from smiling and keeping silent."

Coming up to the centenary of the First World War, Andy's been contemplating what we've learned in the last 100 years, reviewing papers on malaria outbreaks in Salonika (present-day Greece) and Africa. "What the doctors described then is basically what we see now. We've got different drugs, but we're still not very good at education, behaviour modification and training – that's part and parcel of what travel medicine is. We try to get people to do things to reduce their risks, but we're as bad at that today as we've always been."

Any solutions?

"If it was easy we would have done it a long time ago."

'The moment you start leaving out things because you're talking to "educated" people, you start getting things wrong.'

Nowadays Andy is more likely to be advising the advisers than meeting travellers face to face – indeed, one of his roles is to advise the Surgeon General – but he has strong views on pre-travel consultations. "It all comes back to knowing your population, understanding their knowledge and expectations, and then communicating effectively.

"I wouldn't give the same presentation to junior soldiers as I would to very senior officers, but the moment you start leaving out things because you're talking to 'educated' people, you start getting things wrong. That's why I usually try to deconstruct any message and break it down into simple ideas. You have to use your knowledge and experience, and not be afraid to change your approach as you learn what works for you and what doesn't."

Oh, and about that black widow? "Well, she came from the Mojave Desert in an imported 1964 Sunbeam Alpine car that had been stored there. Seems they get quite territorial when they have eggs in tow …



# Off with the lemurs in Madagascar

With apologies to no-one, Sharon Graham MFTM RCPS(Glasg) has been on yet another 'trip of a lifetime'. After all, she says, we only have one life and there's so much to see…

**This was my chance to experience wildlife in its natural habitat on a 12-day trip to Madagascar, perhaps one of the poorest countries I have encountered. India, Sri Lanka and Mozambique all have half decent roads and some sort of education and health system for the majority of the population. Many in Madagascar still have no access to potable water and, since the coup, even fewer have access to health and education than under the previous regime.**

Tourism is the main economy and we were treated to some of the best hotels and facilities available. Sadly the roads have not been repaired for many years.

We did the tourist visit to Lemur Island for a close encounter with these fascinating primates - in recovery, after being abandoned or injured. We also saw what little remains of the rainforest. Venturing into the reserves set aside for tourists (not the pristine primary areas) we were enthralled by encounters with 12 different lemur varieties, admittedly some only 'brown blobs' high in trees.

Our guides reminded us that any sightings are lucky as tracking lemurs, even in reserves, requires significant fitness and energy to scramble up and down steep slopes and over fallen trees. So we were very lucky to see three varieties that are classified as 'critically endangered', two as 'endangered' and the rest as 'near threatened'.

Bird sightings were few and far between until the final three days when we neared the coastal areas. I had a close encounter with several snakes, one of which sidled over my feet, but we were assured that none on the island was venomous. My fellow travellers named me 'the Lord High Executioner' as I kept the list of sightings for flora and fauna (think The Mikado if you're wondering).

Health-wise all went well. From the outset our guide made it clear that none of us would get malaria if he had any say in the matter: each morning he checked we had all taken our malaria prophylaxis. I never did find out if this was as a result of previous or personal experience, but his care was beyond exemplary.

‘When carrying out travel medicals for oil and gas employees, it is worth remembering that the company may have extensive knowledge of the location …’

For over a century, the oil and gas industry has been sending employees around the world in pursuit of natural resources. Dr Jonathan Ross MFTM RCPS(Glasg), Chief Medical Adviser for the BG Group, explains the work of the industry-wide OGP/IPIECA Health Committee and suggests their expertise can be shared with travel medicine practitioners everywhere.

# Travel health and the oil and gas industry

**Of the 56 million UK travellers each year, approximately 12% - about 6.8 million - are engaged in business travel. [1] On a worldwide scale, the International Air Transport Association (IATA) expects about 3.3 billion air travellers in 2014. [2] With the global market and ease of travel, these travellers come from many fields, but one of the longest -established has been the oil and gas industry – both in terms of exploration and production, and in downstream operations. The oil and gas companies have been sending travellers around the world and establishing expatriate assignments for well over a century.**

Some 40 years ago, in 1974, two industry bodies were established to support the oil and gas companies in their work and to promote knowledge of the industry.

## OGP

The International Association of Oil and Gas Producers (OGP) is a unique global forum in which members identify and share best practice to achieve improvements in every aspect of health, safety, the environment, security, social responsibility , engineering and operations. [3] OGP encompasses most of the world’s leading publicly-owned, private and state-owned oil and gas companies, industry associations and major upstream service companies. It represents the industry in UN bodies such as the Commission for Sustainable Development and the International Maritime Organisation, and works with many other international associations. Its core work is achieved by an active and enthusiastic group of committees, taskforces and workgroups.

## IPIECA

IPIECA was originally an acronym for the International Petroleum Industry Environmental Conservation Association, but since 2009, the name IPIECA has been standalone.

IPIECA is the global oil and gas industry association specifically addressing environmental and social issues. Formed following the launch of the United Nation’s Environment Programme, OPIECA is the only global body representing both the upstream and downstream industry in these areas.

IECA helps the industry improve its environmental and social performance by:

- developing, sharing and promoting good practice
- enhancing and communicating knowledge and understanding
- engaging with members and others in the industry
- working with partnership with key stakeholders. [4]

Initially, each organisation had its own health committee, but these were combined in 2003. The combined OGP/IPIECA Health Committee now has about 78 members representing 39 companies from 15 countries. In addition to voting members (representatives of member oil and gas organisations), there are representatives from other groups such as medical evacuation agencies, paramedic and remote clinic providers, experts in health impact assessment and others.

## OGP/IPIECA Health Committee

The Health Committee provides a forum where members can identify, debate and share best health practice. It concerns itself with any health issues that are of relevance to the oil and gas community. These might be occupational hygiene issues such as drilling muds, radiation and benzene or the health and well-being of national employees, including health education and health infrastructure.

However, today as ever, a great deal of oil and gas work takes place in remote or hostile environments, from deserts through tropical jungles to the Arctic. Even in the era of remote teleconferencing, international travel is an immense part of the day-to-day work of these companies and, despite a commendable move to replace foreign staff with national employees whenever possible, the deployment of expatriates and their families shows no real sign of abating.

At present, most of the Health Committee members are doctors - often company chief medical advisers or regional medical advisers- but this is by no means a requirement of the committee itself. It is up to member companies to send whomever they feel can best represent health for them.

For the members, the Health Committee provides a supportive environment in which to exchange ideas, seek advice, share practical experience and be challenged. The committee is multinational and contains a wealth of experience. It is quite possible to find once-cherished sources of wisdom such as Public Health England or NaTHNaC being questioned – initially a sobering experience, but ultimately good for learning!



**A worldwide grasp of local knowledge**
Within the oil and gas industry, we are usually fortunate enough to be able to visit and assess our overseas locations directly. It is still usual in a company with operations in, say, 25 countries, for the medical adviser to have visited most of them, sometimes repeatedly, and to have first-hand knowledge of the local environment, doctors and hospitals.

If a traveller or expatriate is to be deployed to Santa Cruz in Bolivia, Mumbai in India or Mtwara in Tanzania, it is quite likely that the company doctor will have direct knowledge of the working and living environment and the available health provision there, and can often pick up a phone and talk to a local doctor.

Within the Health Committee, members freely share this knowledge and experience for the benefit of travelling employees and contractors. If my company is starting up in Libya, I can readily find a medical colleague with direct experience to prime me before I do my own visit.

In addition to internal debate, the committee has produced many publications over the years, designed to be practical, hands-on aids to those working at the sharp end. These are usually produced in-house by small workgroups of members, sometimes with specialist input, and are periodically revised to keep up to date.

Publications cover a broad range of topics, but some recent examples of relevance to travel medicine include:

- Managing psychosocial risks in the expatriate community (2013)
- Vector-borne disease management programmes (2012)
- Managing health for field operations in oil and gas activities (2011)
- Fitness to work (2011)
- Managing tuberculosis (2010)
- Health aspects of work in extreme climates (2008)
- HIV/AIDS management in the oil and gas industry (in association with GBC) (2005)
- A guide to health impact assessments in the oil and gas industry (2005).

This is a small selection – the full list is available on the IPIECA website at: www.ipieca.org –go to ‘library’ and then ‘health’. **These publications are free for anyone to download.**

When carrying out travel medicals for oil and gas employees, it is worth remembering that the company may have extensive knowledge of the location, and the company medical adviser should be only too happy to advise on local conditions or to discuss tricky fitness issues.

*Can the proposed location cope with a traveller on warfarin? Is Malarone obtainable locally? How far is the nearest acceptable secondary health care facility? How long does it take to evacuate someone?* Give the company medical adviser a call or send an email and discuss it.

Likewise, with your specialist knowledge, perhaps there is something you feel the company might want to know before they send out a family – that ongoing outbreak of dengue, for example.

I think there is enormous potential for the exchange of knowledge, learning and mutual growth through interaction between the Faculty of Travel Medicine and the oil and gas industry – especially through its representative Health Committee whose Secretary, Artemis Kostareli, can tell you more at: Artemis.kostareli@ipieca.org.

Grateful thanks to Artemis for data and quotes.

**References:**
(all accessed 13. 3 .14)

[1] Office of National Statistics. **www.ons.gov.uk/ons/publications.**

[2] IATA **www.iata.org**

[4] IPIECA **www.ipieca.org**

# MEASLES: A highly contagious, highly preventable disease

Worldwide, the Centers for Disease Control and Prevention (CDC) estimate there to be 20 million cases of measles and 164,000 deaths each year, more than half of them in India. Yet in the developed world we almost could be lulled into consigning measles to history. Nicola Meredith AFTM RCPS(Glasg) gives an insight into this potentially fatal disease and explains what happened when a group of children in Wales were left vulnerable.

Measles is one of the most infectious diseases on earth. It is an acute viral illness of airborne or droplet transmission. Individuals are infectious from initial symptoms until four days after the rash has gone and travel is an important aspect in the spread of measles.

Initial symptoms include:

- fever
- malaise
- coryza
- conjunctivitis and cough

followed by an erythematous maculopapular rash starting at the head and spreading to the trunk and limbs over three to four days.

Small red spots with a bluish white centre (Kopliks spots) appear in the mouth one or two days before the rash and are visible for a further one or two days afterwards.

Complications of measles are common (Table 1). In the UK there is around one death for every 5,000 cases. The case fatality ratio is highest in children under 12 months, lower in the age group one-to-nine, but rising again in older children and adults. Complications are more likely in children who are chronically ill, poorly nourished or immunosuppressed.[1]

Measles has been a notifiable disease in England and Wales since 1940 with as many as 800,000 notifications and around 100 deaths having occurred in a single year. Measles vaccination was introduced in the late 1960s, but uptake was poor and it remained a major cause of ill health. Between 1970 and 1988 there were around 13 deaths from acute measles each year.[1]

The measles mumps rubella (MMR) vaccination was introduced in 1988 and with uptake at more than 90%, measles transmission was interrupted.[1] A two dose course of MMR offers good protection and is part of the routine UK schedule (Table 2).

**However, in the late 1990s MMR vaccine uptake fell in the UK in response to claims in a paper published in The Lancet [2] that MMR, autism and bowel cancer were linked.**

**The paper, which received extensive media coverage at the time, has since been formally withdrawn and confidence in the MMR vaccine has been restored.**

**A local outbreak in Wales**

Between 1997 and 2002 in Wales, uptake of one dose of MMR in two year olds fell from 91% to 80%. In some areas the impact was even greater, with a decrease of 19% (from 92% to 73%) in the Abertawe Bro Morgannwg University (ABMU) Health Board area (Figure 1). Consequently by 2012, approximately one in six 11-year-old children in the Swansea area were unprotected by the MMR vaccine as compared to one in nine for this age group across the rest of Wales.[3]

In November 2012, the measles virus was introduced to Wales by four children returning from a holiday camp in southwest England over autumn half term. Two of the cases then spread the virus to 29 other individuals. At the peak of the outbreak the majority of confirmed cases were in children under 15 years of age although there was a considerable number in young adults.

## Common complications

| | |
|---|---|
| Otitis media | Pneumonia |
| **7-9%** | **1-6%** |
| Diarrhoea | Convulsions |
| **8%** | **0.5%** |

**Table 1. Complications of measles[1]**

## More rare complications

Encephalitis

**One in 1,000 cases**

Sub-acute sclerosing pan-encephalitis (SSPE)

**One in 25,000 cases**

**(One in 8,000 cases in children infected under 2 years of age)**





Across Wales communication about the seriousness of measles was shared and the vaccine was offered in schools, hospital-based drop-in clinics, primary care, other health care settings and prisons.

By August 2013, at least 77,805 catch-up doses of MMR had been delivered in response to the outbreak. Almost a quarter were given to those aged between 10 and 18 years. However, despite all these efforts, of the 50,887 children and teenagers who required one or two doses of MMR only 21,493 received them.

In January 2014 there have been reports of a new measles outbreak in a Swansea college,[5] illustrating why it is important that healthcare professionals exercise vigilance in checking MMR status: pre-travel consultations offer an opportunity to do this. There is also a continuing need to be aware of the possibility of measles in travellers.

**References** (all accessed 13.3.14)

[1] Public Health England (2013) Immunisation against infectious disease: the Green Book. Available at: **www.gov.uk/government/uploads/system/uploads/attachment_data/file/147968/Green-Book-Chapter-21-v2_0.pdf**

[2] Wakefield et al. (1998) Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children (RETRACTED 28 January 2010). **www.sciencedirect.com/science/article/pii/S0140673610601754**

[3] Public Health Wales. National immunisation uptake data. Available at: **www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=54144**

[4] Public Health Wales. Measles Outbreak: Data. Available at: **www.wales.nhs.uk/sitesplus/888/page/66389**

[5] Public Health Wales. (2014) New measles outbreak in college sparks further MMR call (news item). Available at: **www.wales.nhs.uk/sitesplus/888/home**

**Further reading**

'Major public health efforts will be needed if the target of eliminating measles in the European Region by 2015 is to be met.' See European Centre for Disease Prevention and Control (ECDC) Annual Epidemiological Report (2013). Available at: **www.ecdc.europa.eu/en/publications/Publications/annual-epidemiological-report-2013.pdf**

'Under the Global Vaccine Action Plan, measles and rubella are targeted for elimination in 5 WHO Regions by 2020.' See: **www.who.int/immunization/diseases/measles/en/**

More on the subject at: **http://search.who.int/search?q=measles&ie=utf8&site=who&client=_en_r&proxystylesheet=_en_r&output=xml_no_dtd&oe=utf8&getfields=doctype**

Also see NaTHNaC and TRAVAX information on measles immunisation for travellers:

- www.nathnac.org/pro/clinical_updates/measles_reminder_050214.htm
- www.travax.scot.nhs.uk/diseases/vaccine-preventable/measles-mumps-rubella.aspx#advicetravellers (login required)

## Facts about MMR1

Given by intramuscular injection

May be given at the same time as other vaccines

A live vaccine should ideally be given at the same time as other live vaccines if indicated.

(If live vaccines cannot be given simultaneously, then a four-week interval is recommended)

MMR is a two dose course:

- the first is routinely given at 12-13 months of age
- the second at three years, four months of age

**Table 2. Facts about MMR[1]**

# Introducing travel medicine for pharmacists in China

The changing demographics of travel in the coming years will see more and more business and tourist travellers from China and other more recently industrialised nations in Asia. Professor Larry Goodyer FFTM RCPS(Glasg) was part of an Anglo-American lecture tour designed to acquaint Chinese pharmacists with a relatively novel concept.

**In October 2013 I gave a day-long introductory seminar on the breadth of travel health to around 200 hospital pharmacists from all over southeast China. This was part of a two week trip during which I gave lectures in major hospitals and universities on clinical pharmacy practice and education in the UK. My wife Sandy and I were looked after amazingly well by our Chinese hosts and we also had time to visit the tourist attractions in Beijing and other cities.**

The travel medicine seminar was held in Changzhou, about 100 miles northwest of Shanghai. I was joined by my colleague Dr Jeff Goad from the University of Southern California. We are both members of the committee of the ISTM Pharmacist Professional Group.

It was not easy to construct an introductory seminar to an audience hardly aware that the subject of travel medicine existed. The other challenge was in the translation, as the custom is for the presenter to explain each slide in English and then wait for the translator to deliver the Chinese version. This made it hard to maintain the flow of the lecture and also the six hours allotted for the day actually meant just three hours of material.

Attempts at humour were often lost in the translation so it was not easy to develop an interaction with the audience. Nonetheless we covered some of the principles of delivering a travel health service and explained how this was increasingly being performed via community-based pharmacies in the USA and UK.

Apart from the broad overview of the subjects, we covered topics such as malaria and immunisation in more detail. Questions at the end of the day suggested the audience understood the principles and saw that there was an increasing need in China.

**More 'drug stores' than pharmacies**

There are a number of travel clinics in the major cities in China and I am sure these are set to expand. It is probably unlikely though that community pharmacy-based services will develop in the same way they have in the US and UK. Although there are many pharmacy stores in China, these are more involved in the sale of medicines than providing health-based services. In fact a qualified pharmacist is not usually present and most medicines are provided without a prescription.

In general there is greater reliance on hospital-based outpatient services than in the UK. In hospitals we visited, the pharmacy outpatient activity was at a much larger scale than in the UK. For instance, intravenous therapy was administered widely on an outpatient basis in vast suites with seating areas to accommodate hundreds of patients at a time for the administration of infusions. Possibly these pharmacists will become involved in some form of outpatient-based delivery of travel medicine services in future years.

**Ancient remedies**

Traditional Chinese medicine (TCM) is extremely popular and the hospital pharmacy department we visited had provision for western and Chinese medicines to both inpatients and outpatients. TCM is a very different discipline to western medicine and relies on the use of plants, minerals and animal products – the latter including mammal, reptile and insect-derived material.

It was interesting to see how these were formulated into an oral liquid in the hospital pharmacies for delivery in unit doses to the wards. It is quite likely that TCM will be applied to a range of ailments associated with travel health in the coming years.

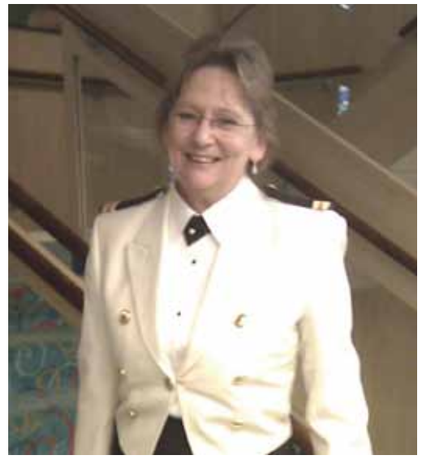
We greatly enjoyed our trip and gained a fascinating view of Chinese pharmaceutical services. I now regularly host Chinese hospital pharmacists who are undertaking internships at both my own university and the University Hospitals of Leicester. They are engaging in developing clinical pharmacy services in China and I believe some Chinese pharmacists will develop an interest and role in travel medicine.



emporiatrics | News, views and reviews from the Faculty of Travel Medicine

# LIFE AS A SHIP'S NURSE: Nautical, but nice!

Carole Tracey FFTM RCPS(Glasg) currently divides her time between duties as an emergency nurse practitioner at the Queen Elizabeth Hospital in King's Lynn and lecturing at Anglia Ruskin University in Cambridge, but she's always been open to new adventures. Her career includes expeditions to Morocco, a healthcare outreach programme in Kenya, educating nurse teachers in Malawi and running a primary care clinic so deep in the Australian outback that it took the Flying Doctors two hours to reach her! Here she shares her experiences on the high seas.



**Who do you work for?**

Fred Olsen Cruise Lines. I worked full time (2011-2012) as a Nursing Officer, and now provide occasional short contract relief. We're small compared to some companies, with only four ships, so you get to know the crew and it's friendly and like a family. It's also really exciting - the Mediterranean and Scandinavia in summer, the Caribbean, Canaries and 'Around the World' in winter.

**What inspired you to go to sea?**

I love travelling. I'd set up and run several travel clinics and often had enquiries about cruising. You think you know what it's like on a ship, but actually, it's nothing like you may think. I wanted some real insider knowledge. I couldn't do it long-term because I couldn't be away from home for four-and-a-half months each contract.

**How did you balance life at sea with home and family?**

My three children are grown up and, until he retired recently, my husband was a GP and very busy, but it was still hard to go away. Sometimes, the family would come for a 'turnaround day', when we disembark guests and bring on the new ones, and they've all come with me for a cruise – after a year, you are allowed to bring along a family member to share your cabin, which makes being away easier.

**How is the ship's Medical Department organised?**

We have a doctor's office, treatment room, nurse's office, pharmacy and laboratory, as well as an ITU room and a ward with two beds. On most cruises, we have one doctor and two nurses – two doctors on long cruises. In addition to clinic hours, the nurses provide a 24-hour on-call emergency service. As 'first responders' to all emergency calls, we assess and treat passengers and crew, as well as manage the critical care for those admitted to the ITU, or arrange repatriation to a hospital ashore. We have a stretcher team made up of crew members, who we have trained in basic life support, and moving and handling.

**What skills should you bring to the job?**

As a ship's nurse, you need to be able to think on your feet. All nurses have the ALS and are from an A&E or ITU background. The company had never had anyone with travel medicine experience before, so I was often asked for my opinions on vaccines yellow fever and diarrhoea.With Fred Olsen we have a mixture of permanent doctors, usually skilled in emergency medicine, and temporary doctors who are usually GPs, many retired, and who are skilled practitioners but not usually in advanced emergency care.

**What sort of emergencies occur?**

Although much of the work is primary care, advanced emergency and trauma skills are frequently required for the accidents, respiratory and cardiac events that can occur to passengers and crew. Working in such an intense environment, a long way from help, you need to be able to deal with anything that's thrown at you.

I've seen more cardiac arrests on a ship than I've seen in the rest of my entire nursing career. We have a good success rate because we are able to be on scene moments after hearing the 'Code Alpha' over the tannoy. The stretcher team bring all our equipment to the scene: AED, oxygen, intubation, cannulation and drugs. We can thrombolyse on board.

Trauma is frequent: people don't think the ship is going to move so we get a number of fractures. One of the most common problems is the passenger who has left their medicines on the kitchen table! We have a limited pharmacy and have to order any medicines from the next port.

Then there's diarrhoea. It's not always norovirus, but this is so contagious that we have a strict 48-hour isolation policy for passengers and crew, and 72 hours for food handlers. We always treat and then monitor patients in their cabins. Should we have a major outbreak, the company will fly out more staff—doctors and nurses—to help.

**Are your clientele more vulnerable than most?**

A lot of ageing passengers go on cruises because they're not fit to fly, and many people travel alone. We'll always look after them and are sensitive to their needs.

**Would you go back to sea?**

After a year, I needed to come back ashore and replenish my knowledge and skills as a nurse practitioner, but yes, I would love to return to sea someday.

**Now your husband has retired, how about going as a team?**

I've tried to persuade him, but he'd rather be a passenger!

TRAVELLER'S TALE

# Hakuna Matata: A day in the life of a rural health clinic in Kenya



While attending the International Society of Travel Medicine (ISTM) Conference in Masstricht last year, Ann McDonald MFTM RCPS(Glasg) was invited to take part in the Kenyan Healthcare Outreach Programme. This led to an extraordinary 'busman's holiday' as we see from her recollections of a 'typical' day.

**The Kenyan Healthcare Outreach Programme was initiated three years ago by nurse volunteers in partnership with Camps International and the Rafiki Kenia Foundation, a non-profit organisation registered with the Council of Kenya to provide healthcare services and support in rural villages.**

The Outreach Programme collaborates with local healthcare professionals and provide free basic healthcare to people in six remote villages on the lower slopes of the Shimba hills in the Kwale District of Southern Kenya.

In November 2013, my husband and I (both nurses) joined an expedition with seven other healthcare professionals. Our purpose was to deliver primary healthcare services to six rural villages in the costal region of Mombasa in Kenya.

Half of Kenya's 43 million people live in rural communities and around 70% of them live below the poverty line with no access to proper sanitation, clean drinking water or healthcare. Education is often limited or non-existent.[1]

**The journey**

Our bags were loaded with generous donations from friends and colleagues: hand knitted teddies, baby hats, toys, old glasses for the Kwale Eye Centre, shoes and flip flops for children, as well as soap, J cloths, bandages and other useful items for the outreach clinics.

After an overnight journey through Amsterdam, Nairobi and Mombasa, we travelled along the costal region on red dusty roads in the baking heat until we reached the small village of Mukaha. Inhabitants of this remote community are the indigenous Digo tribe, who are mainly agricultural workers. The long journey was worth it for the warm welcome by villagers, with children singing and cheering us as our open-topped truck reached the final destination. The greeting "Jambo" was the first of many such welcomes.

Over the next few days we became acclimatised to the heat and more culturally aware, preparing for our work. Armed with a Swahili phrasebook, we were off to set up healthcare clinics in the villages of Muhaka, Zigira, Magaoni, Fihoni, Mkwambani and Makongeni. Services were planned through a multi-agency approach and set up in local schools.

Every day was different of course, but perhaps it would help to give you a flavour of daily life during our time there.

**A typical day**

Each day starts just after 4am with the Imam's call to prayer. The village rustles with chanting, startling the monkeys and birds. Monkeys jump from tree to tree, landing on the roof of our tent and sliding down the side. With the cockerel crowing, dogs barking and bush babies screeching, the animal chorus is entertaining, but it's time now for a cold shower. Then, donning scrubs we start the day's journey to the next village, some distance away.

Preparing to deliver healthcare services has been a major event with over 40 healthcare staff from the UK and local areas providing general treatment and advice – with involvement too from the Government Ministry of Health (Msambweni County.) Plus medical students and nurses from the hospital , Kenyan Red Cross, TB services, dental service, Kwale Eye Centre, religious leaders, village chiefs and many more.

The clinics are set in village schools and moving tables, chairs, pharmacy boxes, laboratory equipment, dental equipment and basins for the jigger programme for each daily clinic is difficult in the heat. The local communities help us get ready for the first patients.

**The daily clinic**

The harsh reality of providing healthcare in Africa is evident as patients arrive, usually having walked barefoot for long distances. They wait to be seen under the shade of mango trees.

It's like thumbing through the pages of a travel or tropical medicine textbook as patients present with conditions rarely seen in the UK. Leprosy (Hanson's Disease), for example, the 'forgotten disease' that has been a World Health Organization success initiative and eradicated in most parts in the world – but not in Msambweni districts. Patients come with badly deformed feet and hands, lacking any sensation in their fingers and feet. Some have known they have leprosy, but could not afford treatment until our free clinic opened.

As the morning wears on patients are assessed with acute and chronic signs and symptoms: coughs, fevers, diarrhoea, stomach pains, urinary symptoms and skin conditions we commonly know in primary care. Others come with hugely swollen limbs and evidence of filarial infections.

**Malaria**

In each clinic, two laboratory technicians carry out Bilharzia and malaria screening, testing thick and thin slides under the microscope. This is a wonderful learning opportunity as the laboratory staff are keen to explain the slides in detail. Some 501 patients will be referred for testing and 174 (35%) will test positive. Babies and young children arrive with temperatures of 40 degrees. A triage system ensures anyone presenting with a fever is seen and treated immediately.

**Jiggers eradication**

A key objective for this programme is raising awareness in the local communities of jiggers, a parasite which burrows into the skin of the feet causing painful sores. The helpers have constructed cement foot bathes at the entrance of each school so children can wash their feet and keep the jigger infestation to a minimum.

This year for the first time a new treatment is using kerosene paraffin mixed with vegetable oil to starve the parasite of oxygen. As jiggers attempt to surface they can be picked off. It's a sustainable choice of materials as paraffin and oil are both readily available. Children have their feet and hands inspected for jiggers and, following treatment, they're given flip flops or shoes to avoid re-infection.

**De-worming programme**

De-worming is a major part of the services. Many children living in poor conditions suffer from debilitating intestinal worm infestations and diarrhoea, resulting in stunted development and disease – under-5s are most at risk. Lack of proper medical facilities, poor nutrition and inadequate public and personal health education compound the problem.

Soil-transmitted helminth infections are among the most common worldwide and affect the poorest and most deprived communities. Eggs are present in human faeces, which in turn contaminate soil where sanitation is poor. The main species that infect people are the roundworm (*Ascaris lumbricoides*), whipworm (*Trichuris trichiura*) and hookworms (*Necator americanus* and *Ancylostoma duodenale*). WHO (2013b)[2] recommends the periodic administration of anthelminthic medicines (albendazole or mebendazole) for the control of these infections. This area is densely populated with children, and the healthcare professionals and community team work tirelessly to hand out medication and make sure children chew the tablets.

**At the end of day**

Volunteering and participating in valuable clinical work was in itself an amazing experience, but it offered me so much more as a healthcare professional, living and working in the villages with the local people.

Our ethos focused on teaching, health promotion and prevention by building professional capacity and developing plans for ongoing sustainable work.

My husband and I were privileged to join in a unique experiential learning opportunity. We thank our friends, colleagues and in particular the College Charities Committee for supporting this worthwhile expedition.

*Ann also worked as a midwife during her stay and we look forward to that account in the next edition. (Ed.)*

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[1]WHO (2013a) Kenya Health Workforce Project, Kenya's Health Workforce Training Capacity: A Situation Analysis, World Health Organization.

[2]WHO (2013b) The 17 neglected tropical diseases. Available at: www.who.int/neglected_diseases/diseases/en/ (accessed 13.3.14)

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## Supporting Africa – without leaving home!

Dr Eric Walker FFTM RCPS(Glasg) decided to do his bit for Africa by going electricity-free for an entire week – he even pulled the plug on his hybrid car.
The aim was to raise funds for Let Us Shine, a Scottish charity that builds schools in rural areas of Ghana, and he also learned what one can do – and do without – in our energy-driven society. Read his fascinating account and donate to his campaign at: www.justgiving.com/Eric-Walker

## ‘Don’t break the law abroad!’

Sound (if obvious) advice from the UK Foreign & Commonwealth Office, but the experiences of those who ignore it are harrowing. In the six months to November 2013, FCO stats showed 32 percent of British detentions abroad were for drug offences and 2,760 British nationals were currently detained overseas. The FCO and the charity Prisoners Abroad are campaigning to highlight the consequences of the use, possession and smuggling of drugs in countries around the world.

Two Brits who spent many years in foreign prisons describe their experiences in a video at: www.gov.uk/government/news/drugs-leave-hundreds-of-brits-behind-bars-overseas. The FCO has reissued Too Late Now, the information film about the risks of drug trafficking at: **www.youtube.com/watch?v=_e5k DDSmWw&feature=youtu.be** Sign up to the FCO’s Facebook and Twitter feeds for the latest travel advice.

## World Malaria Report 2013

According to this WHO report, global efforts to control and eliminate malaria have saved an estimated 3.3 million lives since 2000, reducing malaria mortality rates by 45% globally and by 49% in Africa. But that’s no cause for complacency, said WHO Director-General Dr Margaret Chan, calling for sustained finance. **www.who.int/mediacentre/news/releases/2013/world-malaria-report-20131211/en/**

## BGTHA overview

The 15th National British Global and Travel Health Association Conference last October in Bristol focused on gastrointestinal problems and featured FTM Dean Dr Mike Jones, Consultant in Infectious Diseases, speaking on travellers’ diarrhoea. Contact the Editor for a full review of the event.

The next BGTHA conference addresses maternal and infant health and is on 29 March 2014 in Edinburgh. See: **www.bgtha.org/**

## Delivering immunisation

See the Royal College of Nursing’s new publication Supporting the delivery of immunisation education (code: 004 479) at: www.rcn.org.uk/publications The RCN Public Health Forum encompasses specialties in sexual health, occupational health, travel health and immunisation. A dedicated travel health page includes links to a variety of resources for health professionals. **www.rcn.org.uk/development/practice/public_health/topics/travel_health**

## Don't bring home unwanted souvenirs

A person can travel round the globe in less time than it takes symptoms to appear, according to the UK Chief Medical Officer, highlighting the importance of immunisation against infection. Yet vaccination of adults (over-18 and under-65) remains a woefully under-used public health strategy. See the Supporting Active Aging through Immunisation (SAATI) Report) on adult immunisation at: **http://www.ilcuk.org.uk/index.php/publications/publication_details/immune_response._adult_immunisation_in_the_uk**

# TRIENNIAL SCHOLARSHIP WINNER: Malaria Matters update due online this summer

The Triennial Scholarship of the Faculty of Travel Medicine was introduced in 2011. Open to all Faculty members, it aims to encourage research and innovation in the specialty.

The winner of the inaugural prize was Dr Caroline Turner, a specialist registrar in genito-urinary medicine and HIV whose work was entitled ‘A Cross sectional study investigating the prescription, adherence and tolerability of malaria chemoprophylaxis in HIV positive travellers’. Dr Turner presented her preliminary data at the 2011 Triennial conference of the Royal College of Physicians and Surgeons of Glasgow. The work is now nearing completion, prior to submission for peer-reviewed publication.

The 3rd Triennial meeting of the Faculty of Travel Medicine, to be held in June 2014, will include a short presentation from the most recent scholarship winner, Jane Chiodini FFTM RCPS(Glasg). Malaria Matters was an e-learning course written by Jane in 2008 and based around the HPA (now PHE) Guidelines for malaria prevention in travellers from the UK. It was now time for a full update to reflect changes made to those guidelines.

Winning the scholarship provided Jane with some financial support for the project, including engaging an e-learning developer to make the updates she designed for the material and importantly, to transfer the work onto a more modern and flexible e-learning platform. This means that once she has mastered the software package, she can update the course material in a timely fashion to ensure the content is always fully current.

Malaria Matters is a detailed course which includes videos, case studies, reflective learning and an end-of-course assessment. Previous evaluation identified that nurses in particular have enjoyed and benefited from engagement in this form of learning.

The course should be complete by the summer of 2014 and available online for any healthcare professional to use.

Jane Chiodini: “I thank the Royal College of Physicians and Surgeons of Glasgow for awarding me this scholarship and thus providing help towards developing a useful learning tool for such an important topic in travel medicine.”



## Conferences

16th International Congress on Infectious Diseases

***2-5 April 2014***
Cape Town, South Africa
**www.isid.org/icid**

10th Asia Pacific Travel Health Conference

***7-10 May 2014***
Ho Chi Minh City, Vietnam
**www.apthc2014.org**

CISTM14

***24-28 May 2015***
Québec City, Canada
**www.ISTM.org**

NECTM5 Northern European Conference on Travel Medicine

***5-8 June 2014***
Greighallen
Bergen, Norway
**http://nectm.com**

Joint Conference: ISTM 6th Region & Wilderness Medical Society

***2-6 August 2014***
Jackson Hole, Wyoming
**www.ISTM.org and www.WMS.org**

Joint Conference: RCN and Travel Health Training
*A Return Ticket*

***13 September 2014***
RCN HQ London
**www.rcn.org.uk/newsevents/events**

South African Society of Travel Medicine
*Travel Health Africa – Quo vadis?*

***18-21 September 2014***
Durban
**www.sastm.org.za**

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# ADVANCING EXCELLENCE IN HEALTHCARE 2014

**The Third International Triennial Conference**
*of the Royal College of Physicians and Surgeons of Glasgow*

## 19 - 20 June 2014

Scottish Exhibition and Conference Centre Glasgow

Supported by the Commonwealth Games Federation

**6 CPD POINTS APPROVED**

Nine symposia running in parallel over two days covering the broad themes of medicine, surgery, dentistry, travel medicine, podiatric medicine and history of medicine. The conference will also host the annual Glasgow Lung Conference and symposia by the University of Glasgow and Faculty of Sport and Exercise Medicine. A theme of sports medicine will run through the conference.

## The Travel Medicine symposium on 20 June includes presentations by international speakers on a range of topics including:

- Extreme altitude: reaching for the sky
- Ready, steady go!
- From one extreme to the other

**Register online now!**

*Full details of the conference programme are available to download on the conference website.*

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