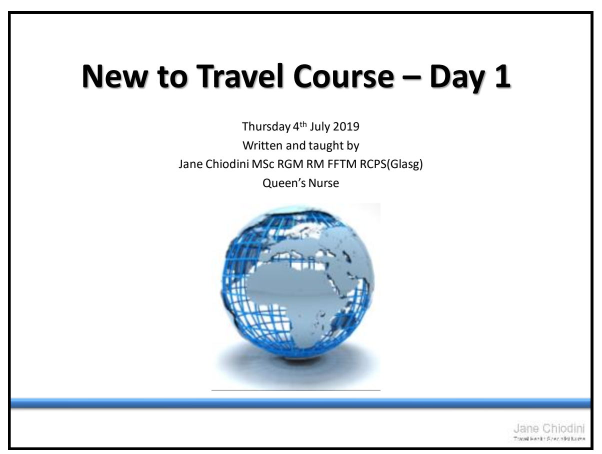

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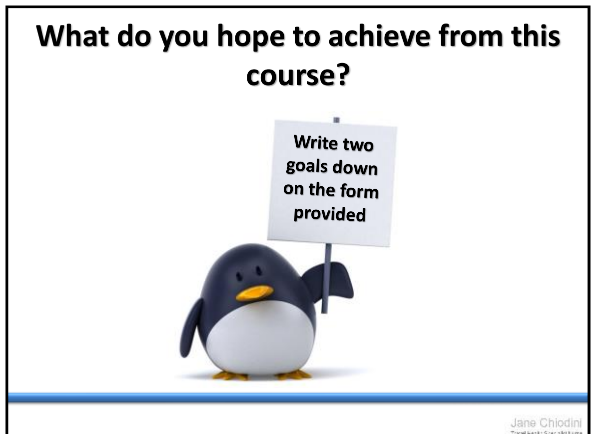

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What are my goals

1. **Today** - I want you to understand the basic principles of a risk assessment, the diseases and vaccines and the resources to help put safe service together
2. **By the end of the two days** I'd like you to go away feeling more 'in control' for travel health, hopefully enthused about the subject and to potentially enjoy it in the future!

Competence comes with time and experience!

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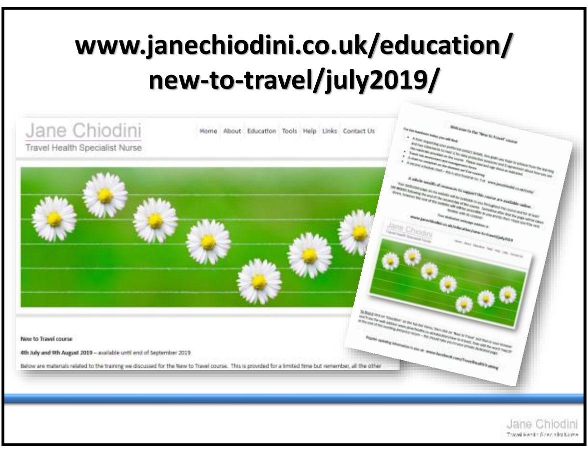

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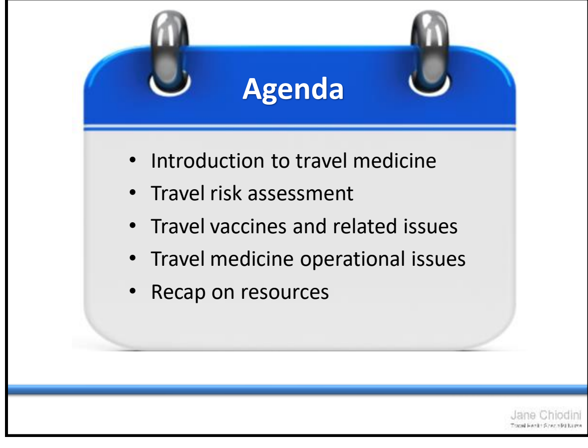

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Recap of the subject onlinelearning

http://www.janechiodini.co.uk/education/online-learning/

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An introduction to travel medicine – the key issues

- The travelling public needs to be well informed not only about their destinations and all of the cultural richness, but also **aware of the potential risks during their journey**
- Equally there needs to be a nucleus of GPs, practice nurses and other trained health professionals who are **knowledgeable about the risks on a country by country basis and who are confident about advising their patients** about each of the measures necessary to keep them healthy while travelling

Field VF, Ford L, Hill DR, eds. Health Information for Overseas Travel, National Travel Health Network and Centre, London, UK, 2010.

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Who provides travel health advice?

- In other countries its traditionally the doctor who sees the traveller and performs the risk assessment, passing them on to the nurse to administer the vaccines and give some advice
- More recently pharmacists have become involved in travel medicine, especially in Canada and the UK
- In the UK, nurses have been undertaking all aspects of travel health since the early 1990s, from risk assessment to administration of vaccines and providing risk management advice. In some cases, nurses who have obtained a non medical prescribing qualification are not only prescribing but in some circumstances setting up and owning their own travel clinics

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Why is the practice of travel medicine different in the UK?

- National Health Service provides some travel vaccines free of charge – service provided in the majority of primary care settings as GPs are financially rewarded for the service
- Pressure on GPs with their workload so historically, they passed travel health on to the nurses, but now pharmacists are getting very involved as well, with private clinics are growing dramatically
- Some surgeries are ceasing the provision of a travel service – however, they are NOT allowed to do this unless they surrender the provision of the global sum which they receive for immunisation services

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www.janechiodini.co.uk/news/faqs/faq-2/

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Charging for travel vaccines in an NHS setting – covered in day 2

- **Vaccines that must always be given as part of NHS provision** (hepatitis A all doses, combination A+B all doses, typhoid, combination typhoid and hep A, polio and cholera)
- **Vaccines that cannot be given as an NHS service** (yellow fever, Japanese encephalitis, tick borne encephalitis and rabies for travel and more recently ACWY for travel – but see FAQ page)
- **Vaccines that can be given as NHS or private service** (hepatitis B)

Note: Cholera and oral typhoid vaccines are now only NHS vaccines in an NHS setting

see http://www.janechiodini.co.uk/news/faqs/faq-no-2/

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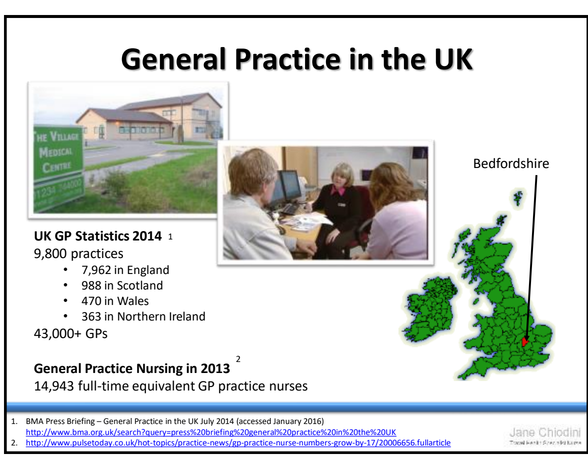

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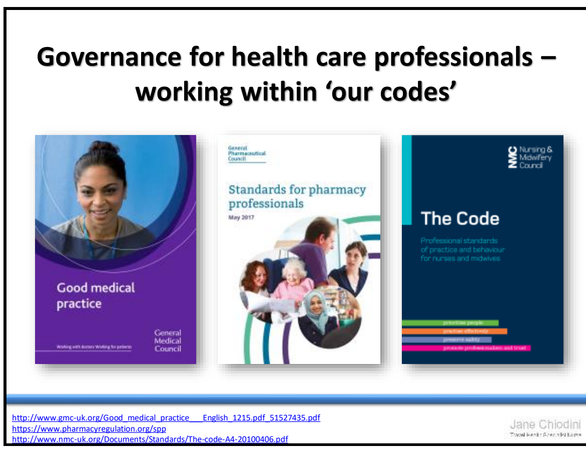

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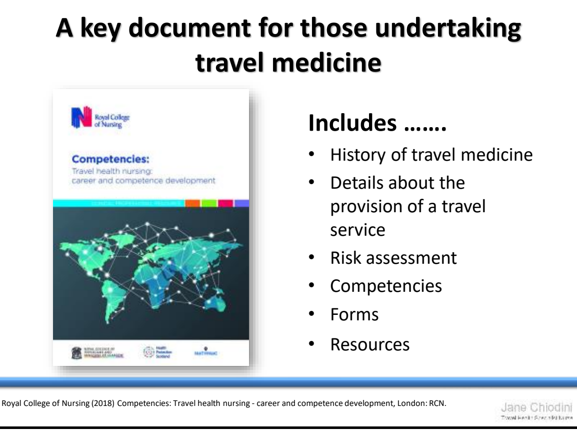

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New inclusions - Page 9

A statement is included for those who run Yellow Fever Vaccination Centres in the UK acknowledging that whilst YF training is not mandatory for all individuals administering the vaccine, both NaTHNaC and Health Protection Scotland (HPS) recommend:

all those responsible for administering YF vaccine complete the training for their own accountability and good practice

Royal College of Nursing (2018) Competencies: Travel health nursing - career and competence development, London: RCN.

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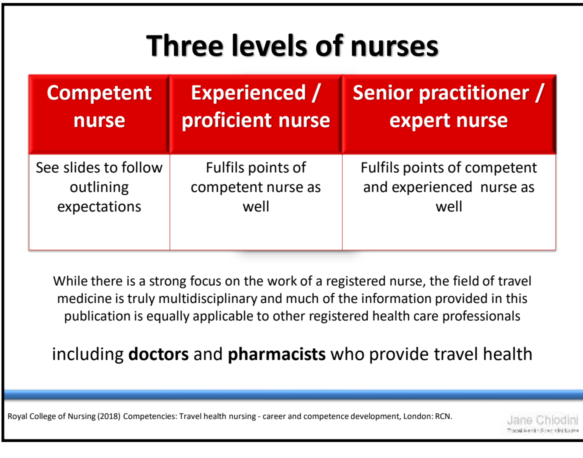

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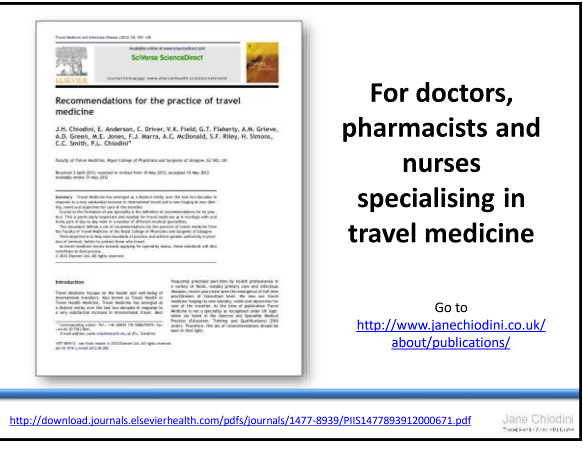

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Core competence for the *Competent Nurse* (or practitioner) in a travel health consultation (pages 21/23)

- Demonstrates good geographical knowledge
- Able to perform risk assessment effectively and understands how to interpret potential risk within a trip
- Knows where to 'go' for recommendations for travel advice, immunisations, malaria chemoprophylaxis
- Recognises limit of knowledge and knows when to refer appropriately
- Has good knowledge of common travel related illnesses e.g. TD, hepatitis, typhoid, malaria

Royal College of Nursing (2018) Competencies: Travel health nursing - career and competence development, London: RCN.

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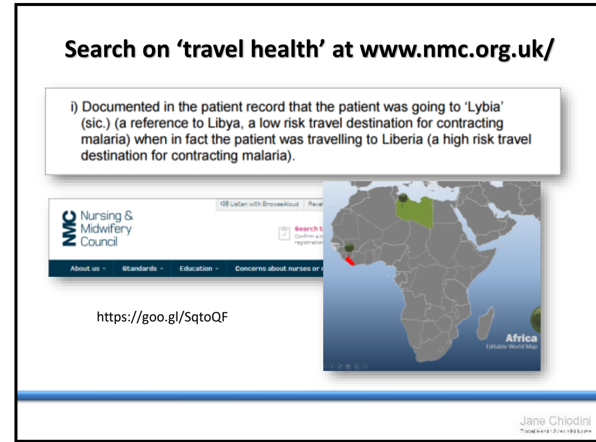
Search on 'travel health' at www.nmc.org.uk/

i) Documented in the patient record that the patient was going to 'Lybia' (sic.) (a reference to Libya, a low risk travel destination for contracting malaria) when in fact the patient was travelling to Liberia (a high risk travel destination for contracting malaria).



https://goo.gl/SqtoQF

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Core competence continued

Able to provide individual advice to the traveller

- ✓ Accident prevention
- ✓ Safe food, water and personal hygiene
- ✓ Prevention of blood-borne infections and sexually transmitted diseases
- ✓ General insect bite prevention
- ✓ Prevention of animal bites, particularly rabies including wound management
- ✓ Prevention of sun and heat complications
- ✓ Personal safely and security
- ✓ Malaria awareness, ABCD advice

Royal College of Nursing (2018) Competencies: Travel health nursing - career and competence development, London: RCN.

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Core competence continued

- Communicates information effectively
- Prioritises in a situation when traveller is on a limited budget
- Assesses anxieties and acts appropriately
- Demonstrates an excellent vaccine administration technique
- Completes patient and administrative records after vaccination

Royal College of Nursing (2018) Competencies: Travel health nursing - career and competence development, London: RCN.

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Education and Training – page 23

- Demonstrates evidence of learning to apply skills and knowledge in the field of travel medicine. For example, minimum of 15 hours of relevant learning plus mentorship in clinical skills before undertaking a travel consultation alone
- Ensures travel health knowledge is always up to date
- Attends an annual travel health update study session/conference at a local, national or international event

Royal College of Nursing (2018) Competencies: Travel health nursing - career and competence development, London: RCN.

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Agenda

- ✓ Introduction to travel medicine
- Travel risk assessment
- Travel vaccines and related issues
- Travel medicine operational issues
- Recap on resources

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Aims and Objectives of this session

- To understand what risk assessment is
- To appreciate the elements of the risk assessment process
- To have a good understanding of the required knowledge and resources needed to perform a risk assessment
- To be able to apply these skills at the end of the course

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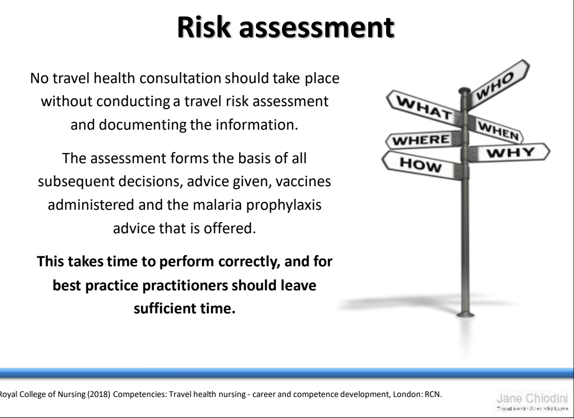

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Time is the major constraint

From the RCN Guidance – page 18

The main consideration is to allocate sufficient time to perform the risk assessment. It would be

unsafe to only allow 10 - 15 minutes

for a new travel appointment.

A **20-minute consultation appointment per person should be allowed** to exercise best practice. Travellers with more complex needs such as backpackers or individuals requiring malaria prevention advice relevant to their destination - **may need even longer** consultation time.

The Nursing and Midwifery Council 'Code' is about being professional, about being accountable and about being able to justify your decisions; employers need to respect the complexity of a travel consultation and appreciate that sufficient time must be allowed for nurses to abide by the Code.

Royal College of Nursing (2018) Competencies: Travel health nursing - career and competence development, London: RCN.

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What is risk?

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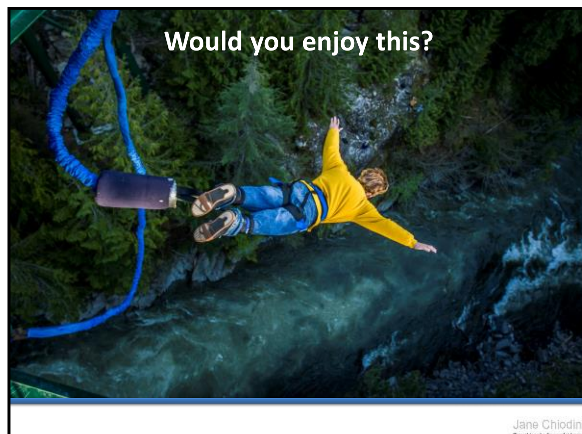

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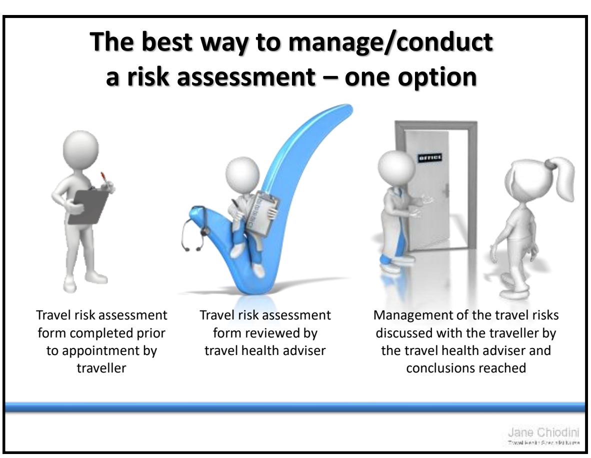

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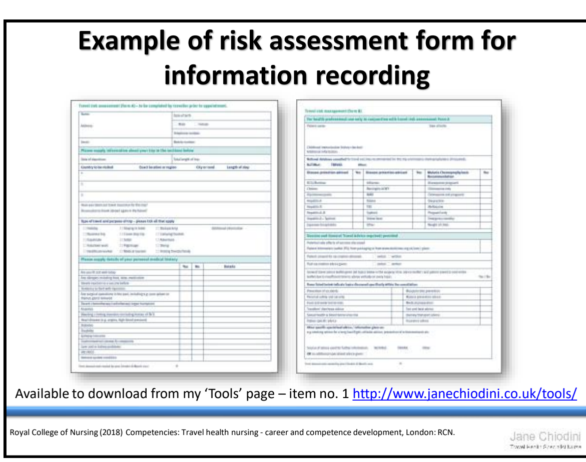

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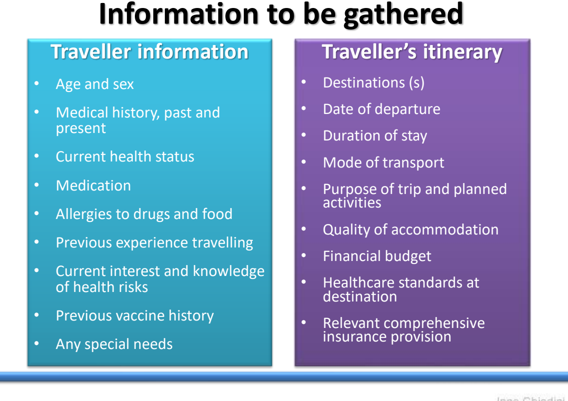

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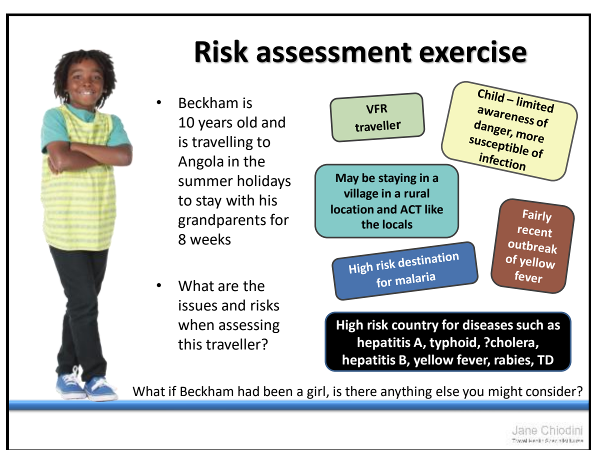

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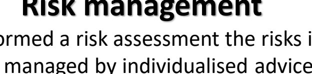

Having performed a risk assessment the risks identified are managed by individualised advice

- Medical preparation
- Journey risks
- Safety risks
- Environmental risks
- Food and water borne risks
- Vector borne risks
- Air borne risks
- Sexual health and blood borne viral risks
- Skin health
- Psychological health

Field VF, Ford L, Hill DR, eds. Health Information for Overseas Travel, National Travel Health Network and Centre, London, UK, 2010.

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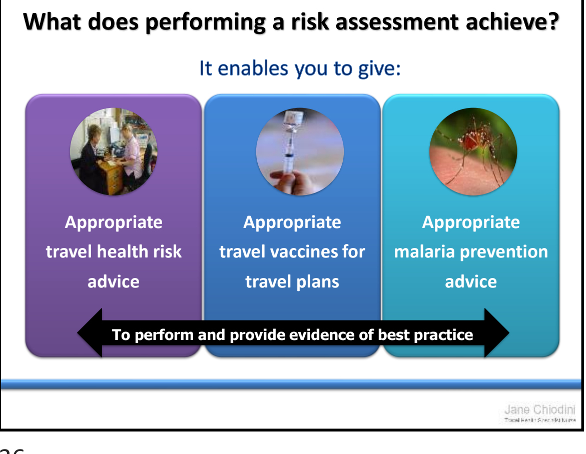

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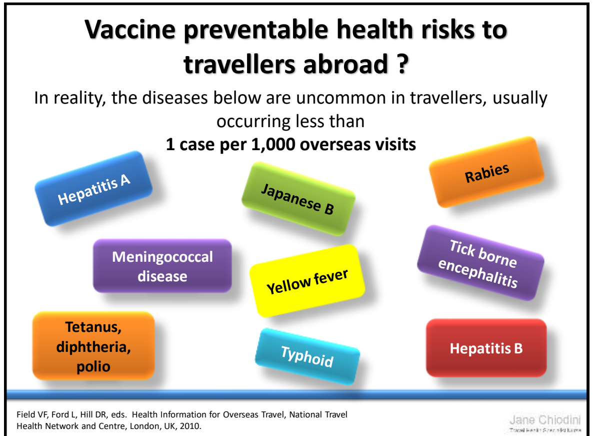

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The role of vaccination

Nevertheless, vaccination is one of the most important public health interventions for global infectious disease control and offers protection for travellers at risk of exposure

Field VF, Ford L, Hill DR, eds. Health Information for Overseas Travel, National Travel Health Network and Centre, London, UK, 2010.

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100%
10% = 1/10
Influenza Belderok 2013, Ratnam 2013
1% = 1/100
Animal bite — rabies risk Gautret 2012
Latent TB infection Brown 2016
0.1% = 1/1,000
Typhoid (South Asia) Greenaway 2014
Measles or Pertussis Dahl 2017
Hepatitis A Nielsen 2012, Dahl 2017
Tick borne encephalitis (rural Baltics) Steffen 2016
0.01% = 1/10,000
Hepatitis B Sonder 2009, Nielsen 2012, Johnson 2013, Dahl 2017
Typhoid (Africa, South America) Greenaway 2014
Active TB (PCV) Brown 2016
0.001% = 1/100,000
Typhoid (Caribbean, Central America) Greenaway 2014
Japanese encephalitis (Pavli 2015)
0.0001% = 1/million
Rabies (Carrera 2013)
Meningococcal dis., poliomyelitis, cholera, yellow fever—(nonimmune, exposed?)
<1/10 million

Estimated incidence per month of vaccine preventable diseases in lower-income countries among non immune Western travellers

Epidemiology: *Morbidity and Mortality in Travelers* in Travel Medicine 4th Edition, Eds. Keystone et al. Elsevier 2019

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Cause of mortality in travellers

Percentage

Cause	Percentage
Cardiovascular	49%
Injury (unintentional)	22%
Medical	13.7%
Cancer	5.9%
Others/Unknown	5.5%
Suicide/Homicide	2.9%
Infectious Disease	1%

Hargarten SW et al. Ann Emergency Med 20:622-626, 1991
This slide was adapted from the ISTM slide set – Introduction to travel medicine 2nd Ed. www.istm.org

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Implications of the questions we ask

Many sources to increase your knowledge and understanding of pre-travel risk assessment in more detail – including on national databases and international resources

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The following slides provide some examples ……
but please refer to the resources on previous slide for more information.

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Age and Sex

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Babies and small children

- Increased risk of other hazards e.g. accidents, encounters with animals – need for rabies post exposure
- Small, mobile, inquisitive toddlers, limited hygiene awareness
- Risk of illness more severe – e.g travellers' diarrhoea, malaria – requiring medical treatment abroad
- Restrictions on some choices of vaccines and malaria chemoprophylaxis

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Older travellers

- Immune systems reduced – infection risk increased
- Senses reduced
- PMH more common
- Immunisation status
- Specific problems e.g. yellow fever vaccine

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Female travellers

- Security risk
- Travelling during pregnancy / breast feeding
- Managing contraception
- Coping with menstruation

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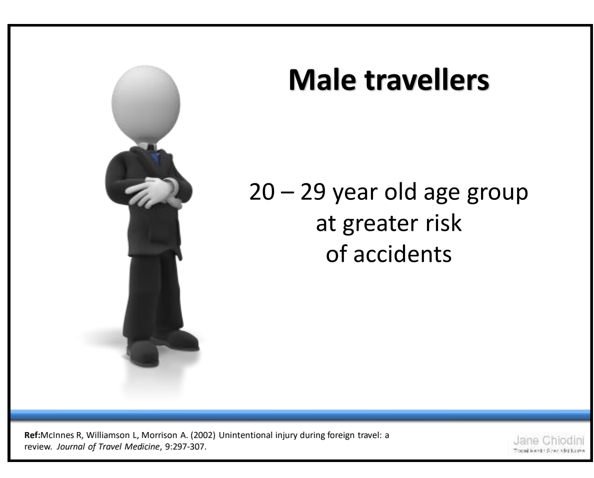

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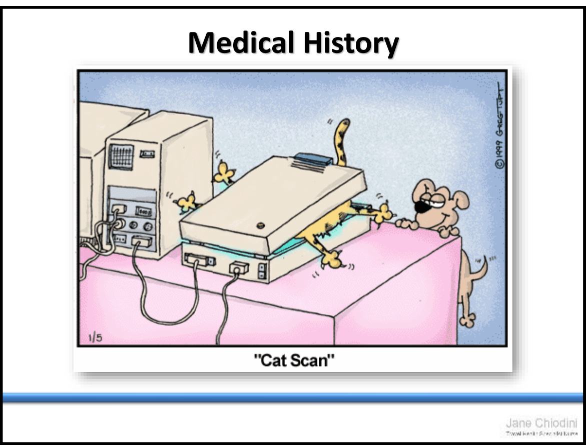

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Medical History

1. Past and present medical history and current health status
2. Medication
3. Allergies to drugs or food/reaction to vaccination

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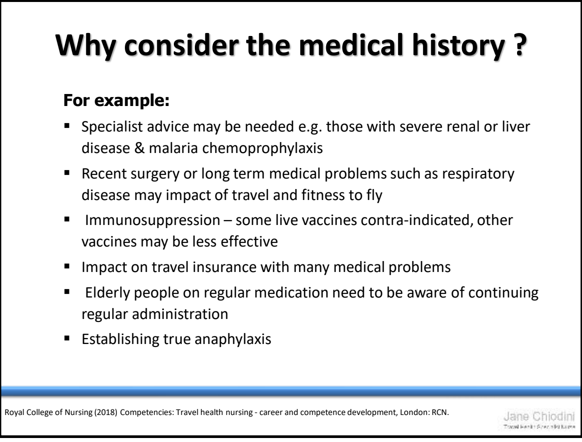

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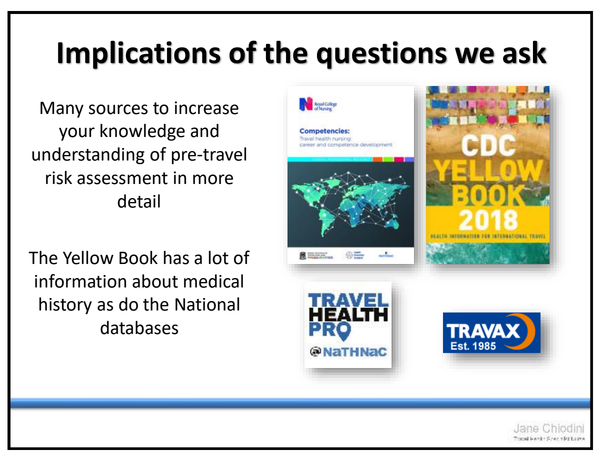

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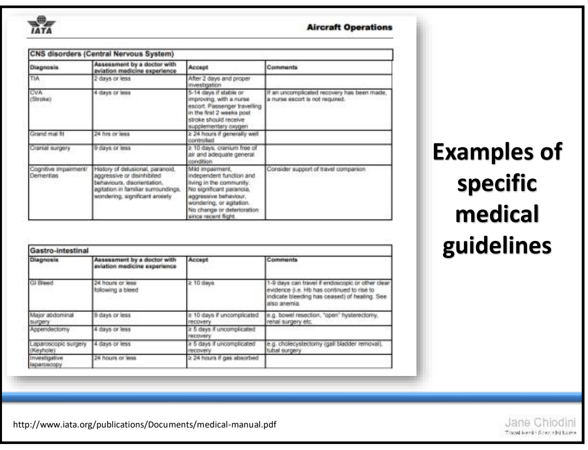
IATA

Aircraft Operations

CNS disorders (Central Nervous System)			
Diagnosis	Assessment by a doctor with aviation medicine experience	Accept	Comments
TIA	2 days or less	After 2 days and proper investigation	
CVA (Stroke)	4 days or less	5-14 days if stable or improving, with a nurse escort. Passenger travelling in the first 2 weeks post stroke should receive supplementary oxygen	If an uncomplicated recovery has been made, a nurse escort is not required.
Grand mal fit	24 hrs or less	≥ 24 hours if generally well controlled	
Cranial surgery	9 days or less	≥ 10 days, cranium free of air and adequate general condition	
Cognitive impairment/ Dementias	History of delusional, paranoid, aggressive or disinhibited behaviours, disorientation, agitation in familiar surroundings, wondering, significant anxiety	Mild impairment, independent function and living in the community. No significant paranoia, aggressive behaviour, wondering, or agitation. No change or deterioration since recent flight.	Consider support of travel companion

Gastro-intestinal			
Diagnosis	Assessment by a doctor with aviation medicine experience	Accept	Comments
GI Bleed	24 hours or less following a bleed	≥ 10 days	1-9 days can travel if endoscopic or other clear evidence (i.e. Hb has continued to rise to indicate bleeding has ceased) of healing. See also anemia.
Major abdominal surgery	9 days or less	≥ 10 days if uncomplicated recovery	e.g. bowel resection, "open" hysterectomy, renal surgery etc.
Appendectomy	4 days or less	≥ 5 days if uncomplicated recovery	
Laparoscopic surgery (Keyhole)	4 days or less	≥ 5 days if uncomplicated recovery	e.g. cholecystectomy (gall bladder removal), tubal surgery
Investigative laparoscopy	24 hours or less	≥ 24 hours if gas absorbed	

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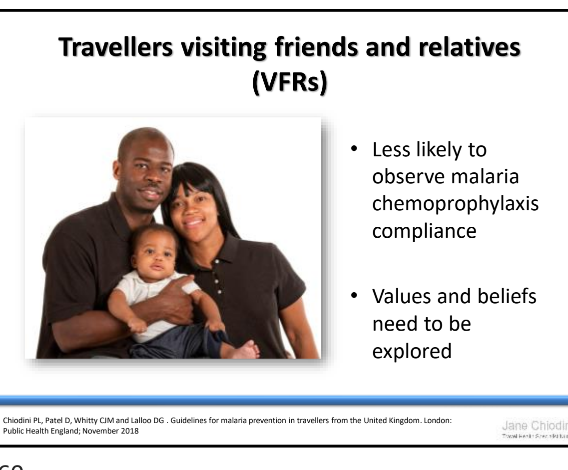

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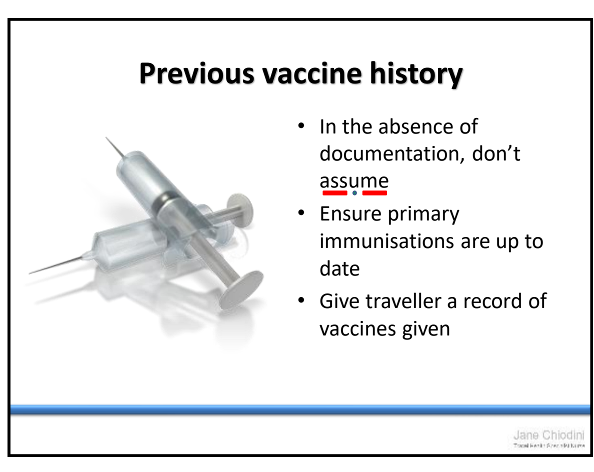

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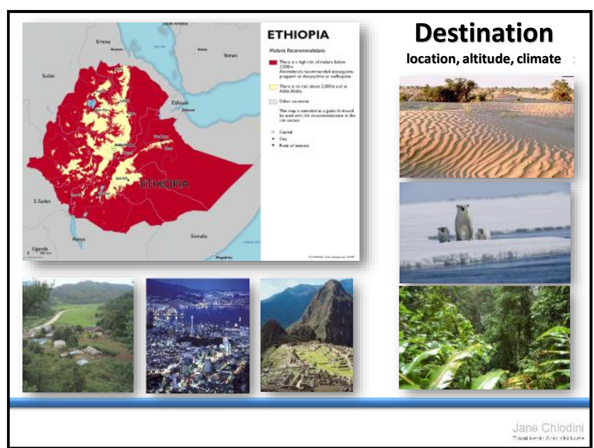

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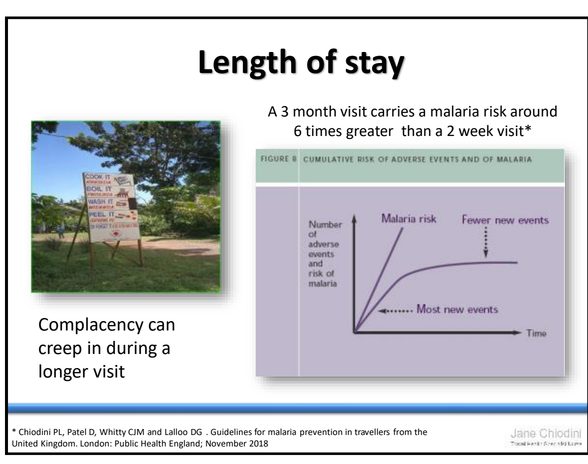

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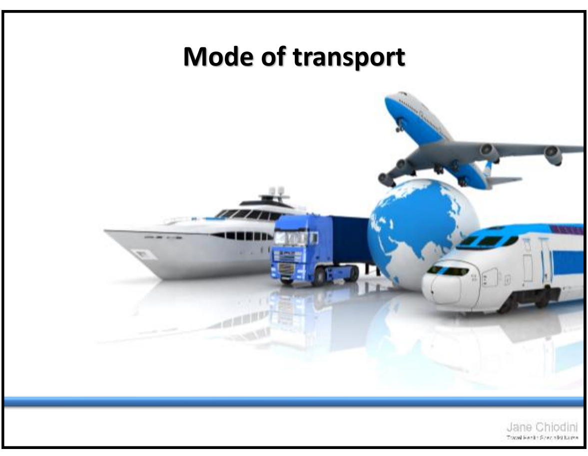

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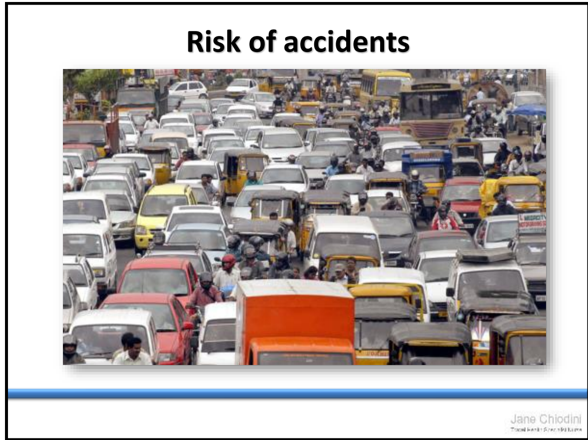

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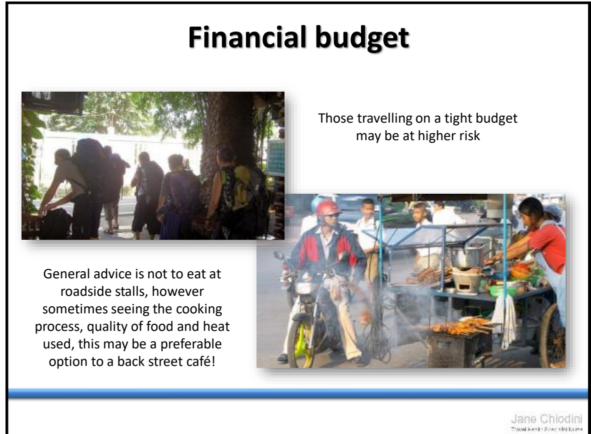

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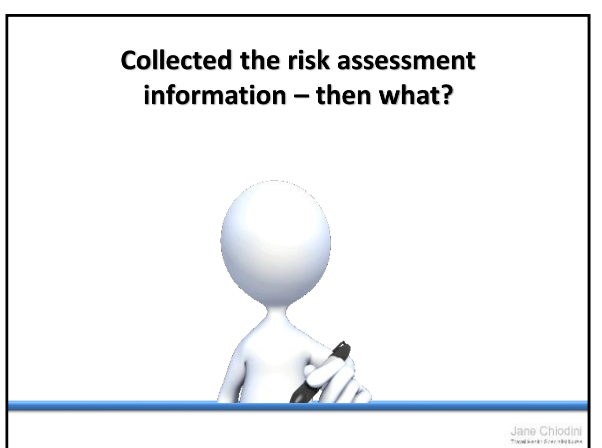

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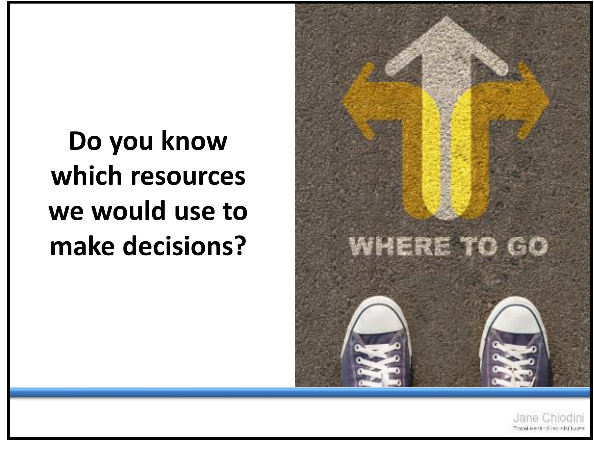

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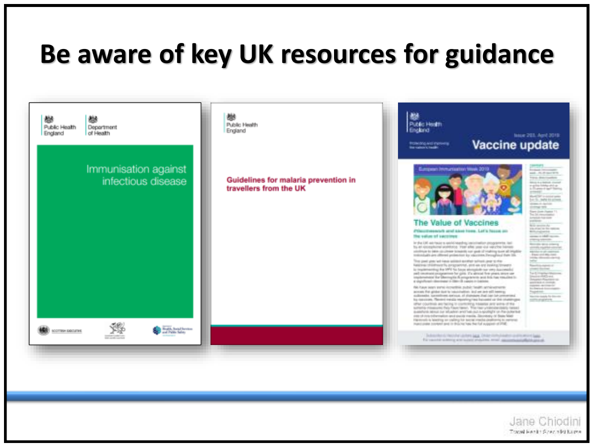
Be aware of key UK resources for guidance



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UK National databases - www.travax.nhs.uk and for the public - www.fitfortravel.nhs.uk

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https://travelhealthpro.org.uk/

From NaTHNaC for healthcare professionals and the general public

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Access via your page and the 'New to Travel' page on my website

Please note, if using TRAVAX, you will still need a user name and password

http://www.janechiodini.co.uk/tools/new-to-travel/

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Review the country specific information on a national database e.g. TravelHealthPro or TRAVAX

- Taking into consideration any patient specific factors (e.g. medical history, how high risk the destination is etc.) review the vaccines advised and decide what is needed – based also on previous vaccine history
- If a malarious area, also decide risk and identify appropriate chemoprophylaxis
- Consider advice required to manage the risks identified

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Communicating the risk and providing advice

- Providing information about vaccines sufficient to provide adequate information to obtain informed consent
- Discussion of what is necessary and desirable – taking time and cost into the equation
- Advising on malaria prevention advice and deciding with patient the most suitable chemoprophylaxis
- Delivering other appropriate travel health advice – some will need to be in written format

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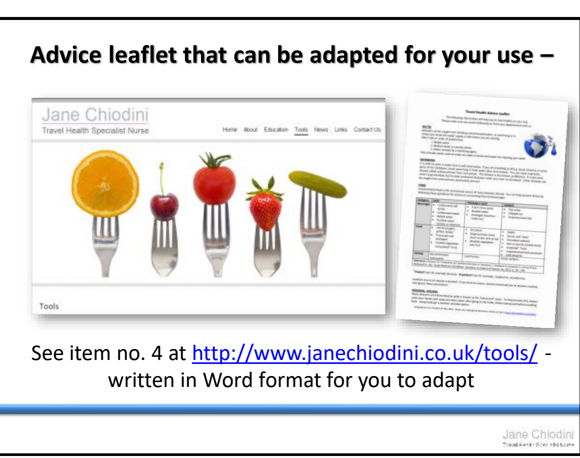
Advice leaflet that can be adapted for your use –



See item no. 4 at http://www.janechiodini.co.uk/tools/ - written in Word format for you to adapt

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Food, water and personal hygiene advice

- Always wash hands before eating or preparing food
- Boiled water, bottled water - this includes ice cubes in drinks and water for cleaning your teeth
- Only eat well cooked fresh food
- Avoid leftovers and reheated food
- Ensure meat is thoroughly cooked
- Eat cooked vegetables, avoid salads
- Only eat fruit you can peel
- Never drink unpasteurised milk and avoid ice cream
- Shellfish is a high risk food

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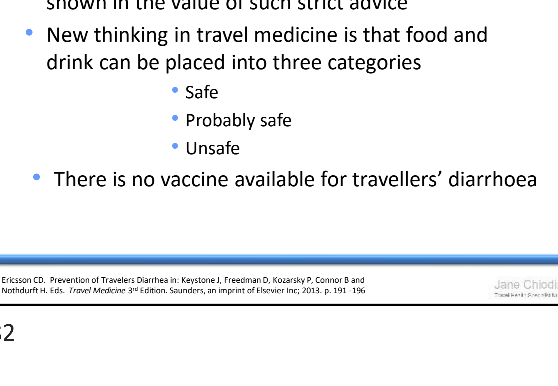

- Studies have shown that the "Cook it, peel it, boil it or forget it" directive is not followed by many travellers and that conflicting results have been shown in the value of such strict advice
- New thinking in travel medicine is that food and drink can be placed into three categories
    - Safe
    - Probably safe
    - Unsafe
- There is no vaccine available for travellers' diarrhoea

Ericsson CD. Prevention of Travelers Diarrhea in: Keystone J, Freedman D, Kozarsky P, Connor B and Nothdurft H. Eds. *Travel Medicine* 3rd Edition. Saunders, an imprint of Elsevier Inc; 2013. p. 191 -196

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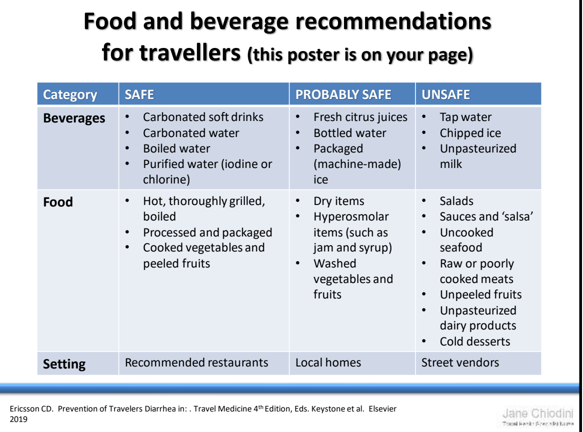
Food and beverage recommendations for travellers (this poster is on your page)



Category	SAFE	PROBABLY SAFE	UNSAFE
Beverages	• Carbonated soft drinks • Carbonated water • Boiled water • Purified water (iodine or chlorine)	• Fresh citrus juices • Bottled water • Packaged (machine-made) ice	• Tap water • Chipped ice • Unpasteurized milk
Food	• Hot, thoroughly grilled, boiled • Processed and packaged • Cooked vegetables and peeled fruits	• Dry items • Hyperosmolar items (such as jam and syrup) • Washed vegetables and fruits	• Salads • Sauces and 'salsa' • Uncooked seafood • Raw or poorly cooked meats • Unpeeled fruits • Unpasteurized dairy products • Cold desserts
Setting	Recommended restaurants	Local homes	Street vendors

Ericsson CD. Prevention of Travelers Diarrhea in: . Travel Medicine 4th Edition, Eds. Keystone et al. Elsevier 2019

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Food water and personal hygiene advice...

(this poster is on your page)

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Travellers' diarrhoea advice

- **High risk areas** include North Africa, sub-Saharan Africa, the Indian Subcontinent, S.E. Asia, South America, Mexico and the Middle East
- **Medium risk areas** include the northern Mediterranean, Canary Islands and the Caribbean Islands
- **Low risk areas** include North America, Western Europe and Australia

Management

- Rehydration
- Anti diarrhoeal tablets
- Standby emergency treatment could be an option for some

Contact medical help if the affected person has:-

- A temperature
- Blood in the diarrhoea
- Diarrhoea for more than 48 hours (or 24 hours in children)
- Becomes confused

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Prevention advice for hepatitis B, C and HIV infection

- Only accept a blood transfusion when essential
- If travelling to a resource poor country, take a sterile medical kit
- Avoid high risk procedures e.g. ear and body piercing, tattooing & acupuncture
- Avoid casual sex, especially without using condoms

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Malaria prevention advice - the ABCD rules !

Photo credit: James Gathany

More information on malaria on day 2 of this course

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Rabies advice

1. Do not touch any animal, even dogs and cats
2. If you are licked on broken skin, scratched or bitten in a country which has rabies, wash the wound thoroughly with soap and running water for 15 minutes then apply antiseptic.
3. Seek medical advice IMMEDIATELY, even if you have been previously immunised.

More information on rabies on day 2 of this course

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Prevention of accidents advice

- Avoid alcohol and food before swimming
- Never dive into water where the depth is uncertain
- Only swim in safe water, check currents, sharks, jellyfish etc.
- Avoid alcohol when driving, especially at night
- Avoid hiring motorcycles and mopeds
- If hiring a car, rent a large one if possible, ensure the tyres, brakes and seat belts are in good condition
- Use reliable taxi firms, know where emergency facilities are

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Risk management and the importance of documentation

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Risk management form helps to 'record' best practice within the travel consultation

Form can be found in 'Tools' – item no. 2 http://www.janechiodini.co.uk/tools/

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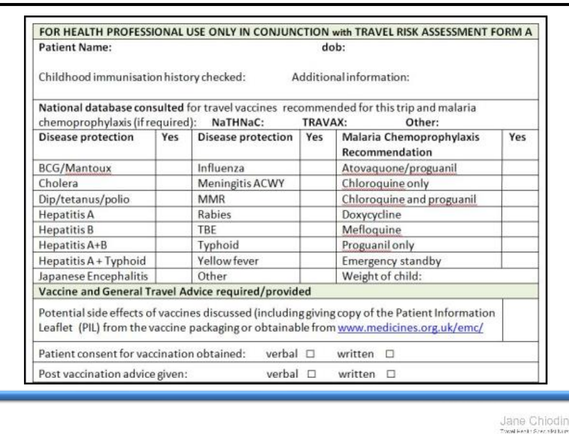

FOR HEALTH PROFESSIONAL USE ONLY IN CONJUNCTION with TRAVEL RISK ASSESSMENT FORM A

Patient Name: dob:

Childhood immunisation history checked: Additional information:

National database consulted for travel vaccines recommended for this trip and malaria chemoprophylaxis (if required): **NaTHNaC: TRAVAX: Other:**

Disease protection	Yes	Disease protection	Yes	Malaria Chemoprophylaxis Recommendation	Yes
BCG/Mantoux		Influenza		Atovaquone/proguanil	
Cholera		Meningitis ACWY		Chloroquine only	
Dip/tetanus/polio		MMR		Chloroquine and proguanil	
Hepatitis A		Rabies		Doxycycline	
Hepatitis B		TBE		Mefloquine	
Hepatitis A+B		Typhoid		Proguanil only	
Hepatitis A + Typhoid		Yellow fever		Emergency standby	
Japanese Encephalitis		Other		Weight of child:	

Vaccine and General Travel Advice required/provided

Potential side effects of vaccines discussed (including giving copy of the Patient Information Leaflet (PIL) from the vaccine packaging or obtainable from www.medicines.org.uk/emc/

Patient consent for vaccination obtained: verbal ☐ written ☐

Post vaccination advice given: verbal ☐ written ☐

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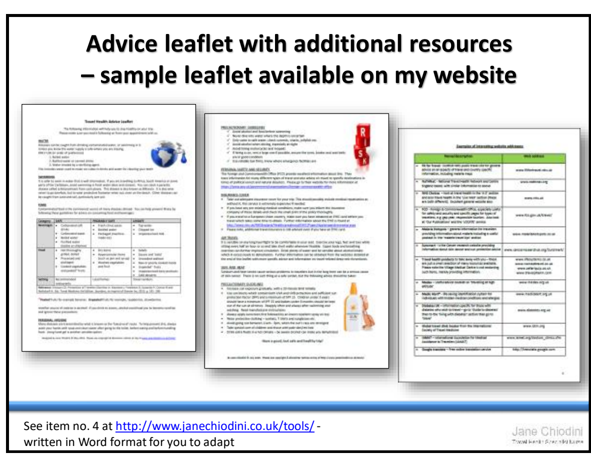

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General travel advice leaflet given (all topics below in the surgery advice leaflet) and patient asked to read entire leaflet due to insufficient time to advise verbally on every topic: **Yes / No**

Items ticked below indicate topics discussed specifically within the consultation:

Prevention of accidents		Mosquito bite prevention	
Personal safety and security		Malaria prevention advice	
Food and water borne risks		Medical preparation	
Travellers' diarrhoea advice		Sun and heat advice	
Sexual health & blood borne virus risk		Journey/transport advice	
Rabies specific advice		Insurance advice	

Other specific specialised advice / information given on:

e.g. smoking advice for a long haul flight; altitude advice; prevention of schistosomiasis etc.

Source of advice used for further information: NaTHNaC TRAVAX Other

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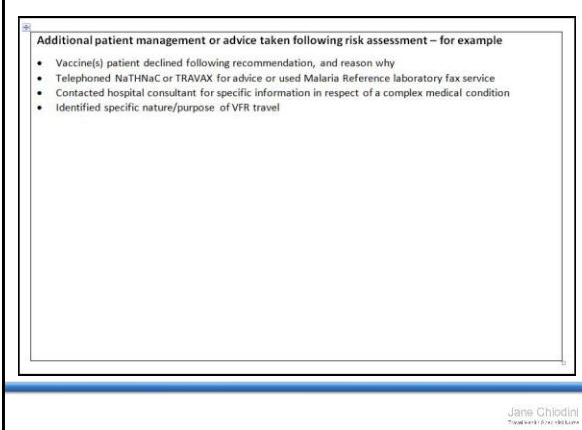

Additional patient management or advice taken following risk assessment – for example

- Vaccine(s) patient declined following recommendation, and reason why
- Telephoned NaTHNaC or TRAVAX for advice or used Malaria Reference laboratory fax service
- Contacted hospital consultant for specific information in respect of a complex medical condition
- Identified specific nature/purpose of VFR travel

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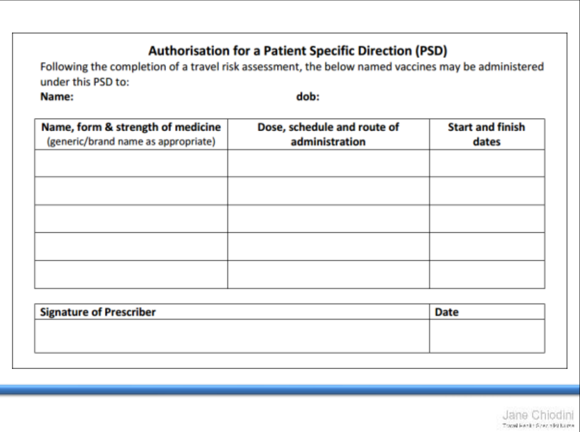

Authorisation for a Patient Specific Direction (PSD)

Following the completion of a travel risk assessment, the below named vaccines may be administered under this PSD to:

Name: dob:

Name, form & strength of medicine (generic/brand name as appropriate)	Dose, schedule and route of administration	Start and finish dates

Signature of Prescriber	Date

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- The template of this form could be adapted to use within a computer system, e.g. EMIS or Systm One
- If using paper copy of the form, then scan in after completion

Post Vaccination administration

Vaccine details recorded on patient computer record (vaccine name, batch no., stage, site, etc.)	**Y / N**
SMS vaccines reminder or post card reminder service set up	**Y / N**
Travel record card supplied or updated:	**Y / N**
Travel risk management consultation performed by: (sign name and date)	

Form devised and created by Jane Chiodini © Updated May 2013

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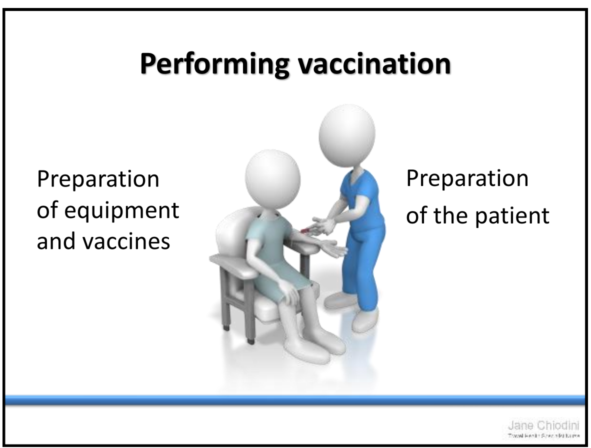

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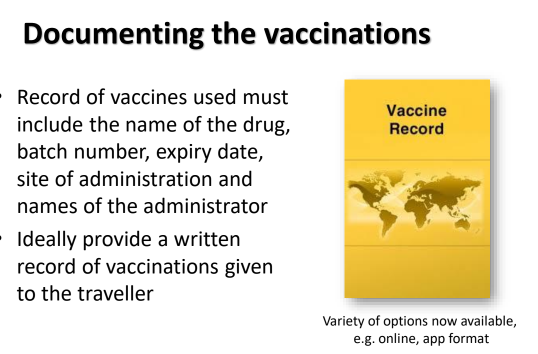

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Conclusion

- No travel health consultation should take place without conducting a travel risk assessment and documenting all the information
- The assessment forms the basis of all subsequent decisions, advice given, vaccines administered and malaria prophylaxis advice that is offered
- Risk assessment and management takes time to perform correctly, and for best practice practitioners should leave sufficient time
- Good documentation is essential

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Agenda

- ✓ Introduction to travel medicine
- ✓ Travel risk assessment
- Travel vaccines and related issues
- Travel medicine operational issues
- Recap on resources

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Vaccine preventable diseases and related issues

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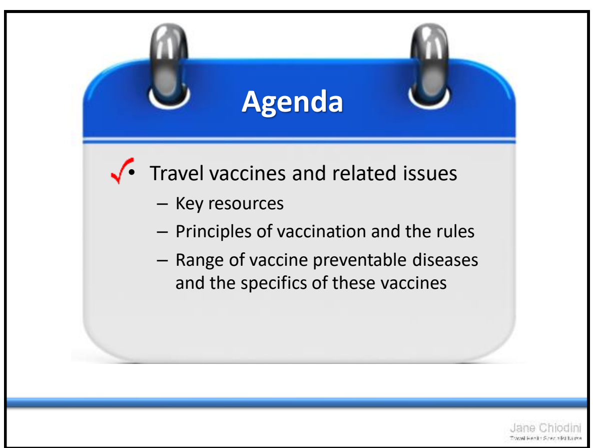

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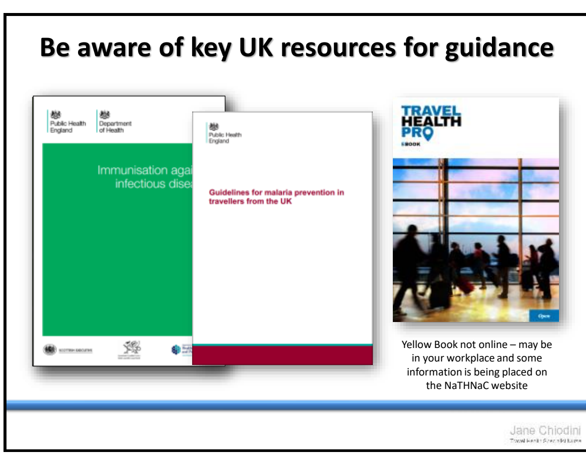

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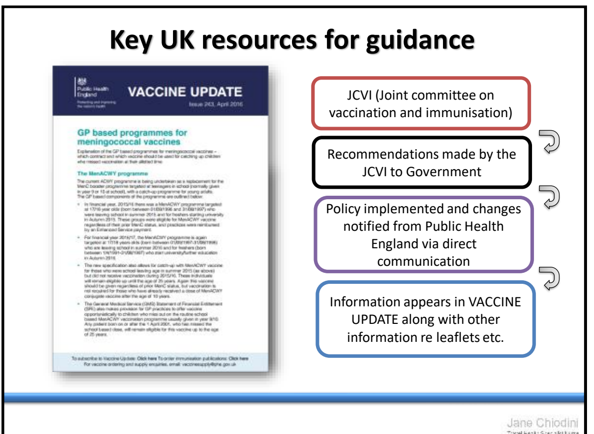

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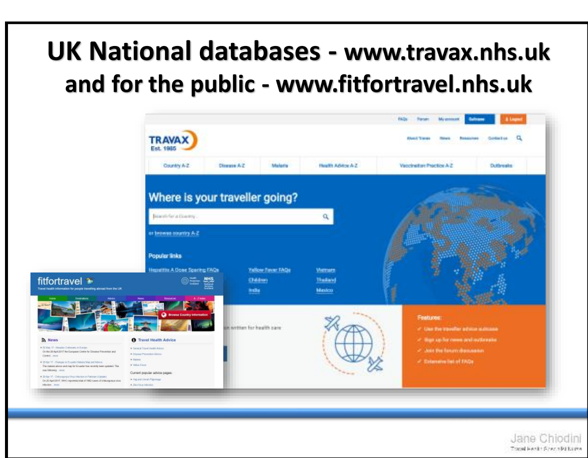

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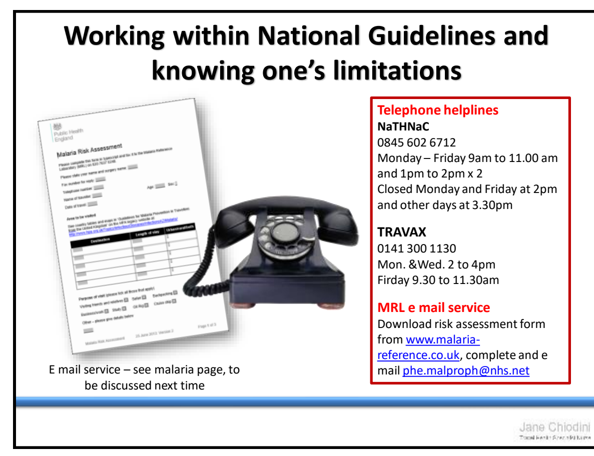

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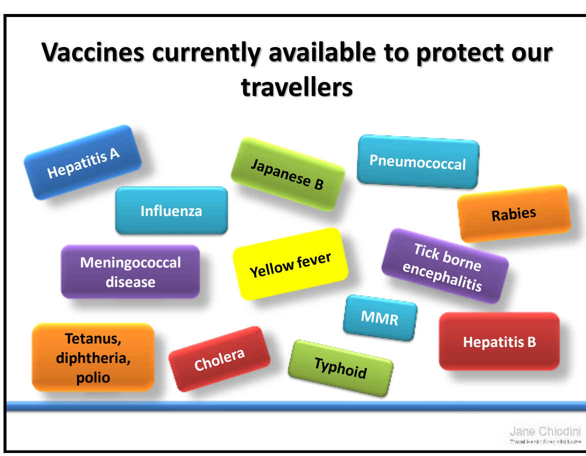

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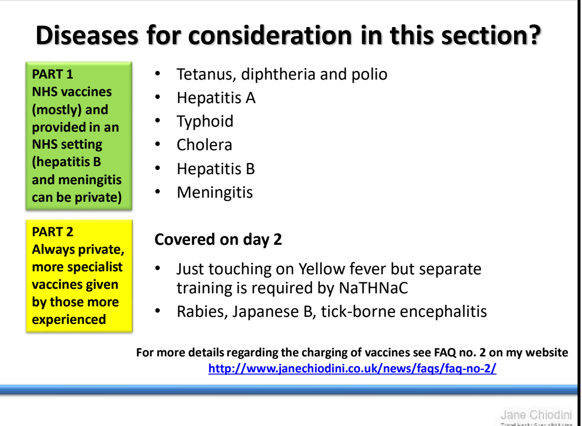

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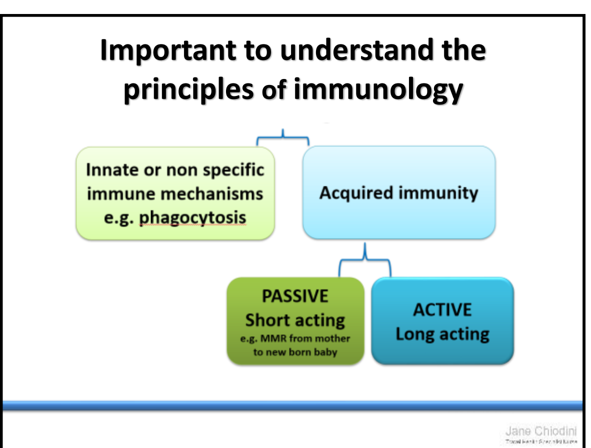

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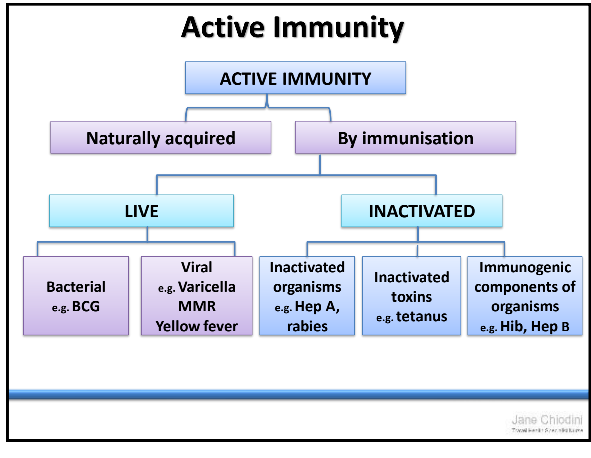

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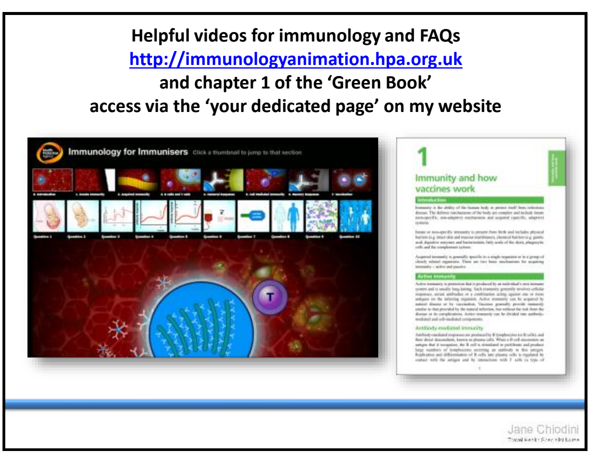
Helpful videos for immunology and FAQs
http://immunologyanimation.hpa.org.uk
and chapter 1 of the 'Green Book'
access via the 'your dedicated page' on my website



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Another useful video published in May 2018

https://www.ovg.ox.ac.uk/news/how-do-vaccines-work

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Do you know what factors might effect the immune response to a vaccine?

Age | **Medical history**

- Very young children (especially under 2 years) have difficulty developing an immune response to polysaccharide only vaccines, and conjugated vaccines are used where possible
- Immunocompromised individuals usually cannot receive live attenuated vaccines. Inactivated vaccines are usually safe, but their immune response may be inadequate

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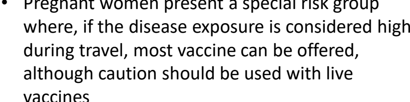
When might there be a contraindication to vaccinate?



- In general, a vaccine is absolutely contraindicated if a person has a confirmed anaphylactic reaction to a previous dose of the vaccine or product contained in the vaccine
- Pregnant women present a special risk group where, if the disease exposure is considered high during travel, most vaccine can be offered, although caution should be used with live vaccines
- All centres administering vaccines must be adequately prepared to deal with anaphylaxis

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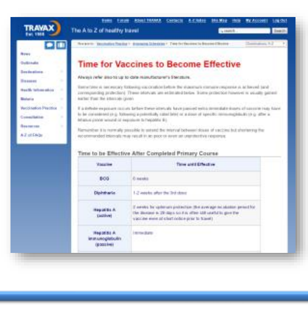
Knowledge of the route we give vaccines and how soon they start to work is needed

- Most vaccines given by IM or SC route except BCG and oral vaccines (cholera and live typhoid)
- An active immune response to vaccines begins within a few days of administration and peaks in approximately 10-14 days
- Primary vaccine courses need 2 or 3 doses to complete the series



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Time for Vaccines to become effective

Table adapted from TRAVAX

Vaccine	Time until effective
BCG	6 weeks
Diphtheria	1-2 weeks after 3rd dose
Hepatitis A (active)	2 weeks for optimum protection (the average incubation period for the disease is 28 days so it is often still useful to give the vaccine even at short notice prior to travel)
Hepatitis A immunoglobulin (passive)	Immediate
Hepatitis B	I month after the 3rd dose
Japanese encephalitis	7 days after the 2nd dose, IXIARO® (Novartis) 1-2 weeks after the 2nd dose, Green Cross vaccine (MASTA)
Measles/Mumps/Rubella (MMR)	2 weeks
Meningococcal vaccines (including ACW135Y)	2 weeks
Poliomyelitis (inactivated)	1-2 weeks after 3 doses
Rabies	1-2 weeks (after the 3rd dose)
Tetanus	1-2 weeks after the 3rd dose
Tick-borne encephalitis	2 weeks after the 2nd dose
Typhoid injectable	1-2 weeks
Yellow fever	10 days

http://www.travax.nhs.uk/vaccination-practice/arranging-schedules/time-for-vaccines-to-become-effective/

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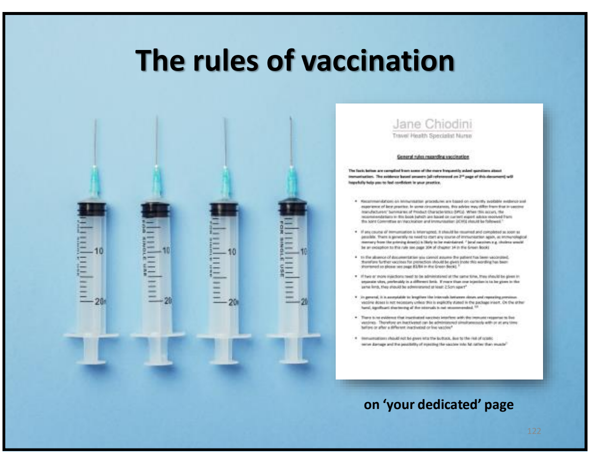

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Peter thinks he has had 2 doses of hepatitis A vaccine in the past, but nothing is documented. He's going to travel to do some research work in a hospital in India – what would you do?

In the absence of documentation you cannot

ASSUME

the patient has been vaccinated, therefore further vaccines for protection should be given

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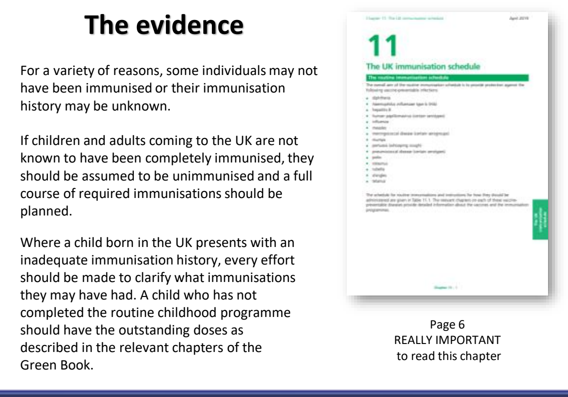

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Michelle had a first Havrix Junior Monodose at the age of one but never returned to complete the course, how would you proceed?

The evidence – chapter 11 again

Immunological memory from priming dose(s) are likely to be maintained in healthy individuals, increasing that interval will usually lead to a more pronounced response to the later dose. **Therefore, where any course of immunisation is interrupted, there is normally no need to start the course again - it should simply be resumed and completed as soon as possible**. Where vaccination was commenced some time previously however, the product received may have changed and the relevant chapter should therefore be consulted.

https://www.gov.uk/government/publications/immunisation-schedule-the-green-book-chapter-11

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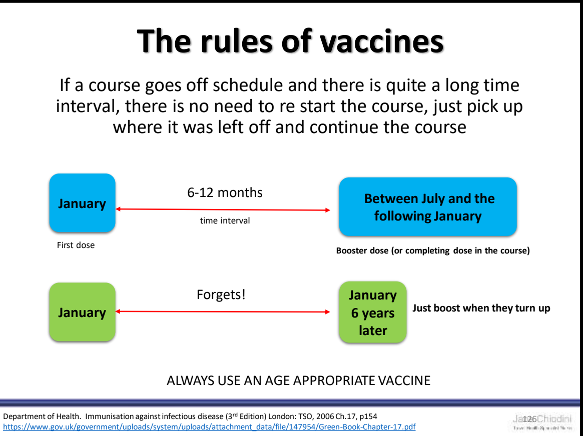

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Jon is backpacking around SE Asia for 6 months and is having a course of rabies vaccine. He had his day 0 dose today but won't be around for the day 7 dose and asks if he can attend in 5 days instead for his second dose.
What would you advise ?

The evidence

In general, it is acceptable to lengthen the intervals between doses and repeating previous vaccine doses is not necessary unless this is explicitly stated in the package insert. On the other hand, significant shortening of the intervals is not recommended

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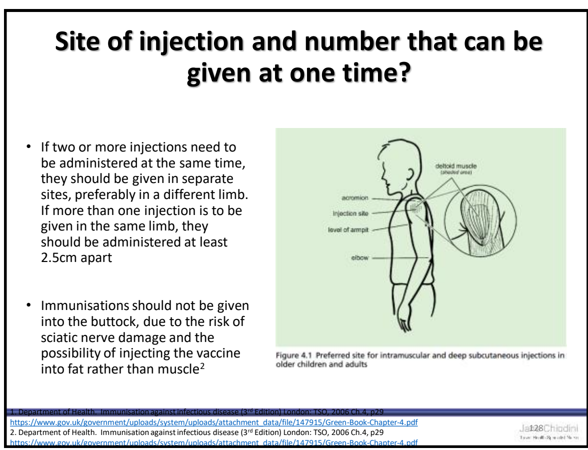

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Where do you obtain relevant vaccine information?

- Green Book – for diseases and vaccines, online
- The National Databases (NaTHNaC and TRAVAX)
- Patient Group Directions - in your workplace
- Electronic Medicines Compendium - online
- British National Formulary – book or online
- Pharmaceutical companies - online

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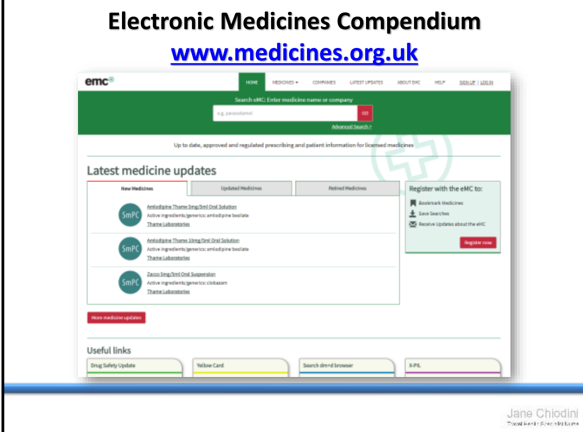

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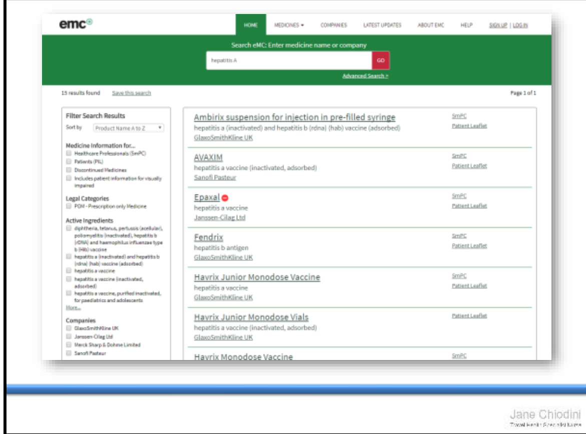

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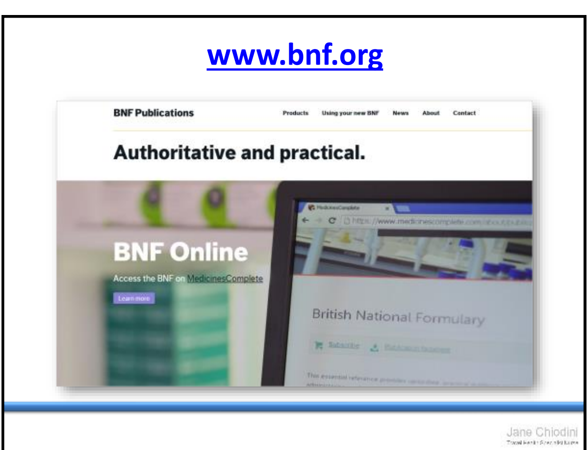

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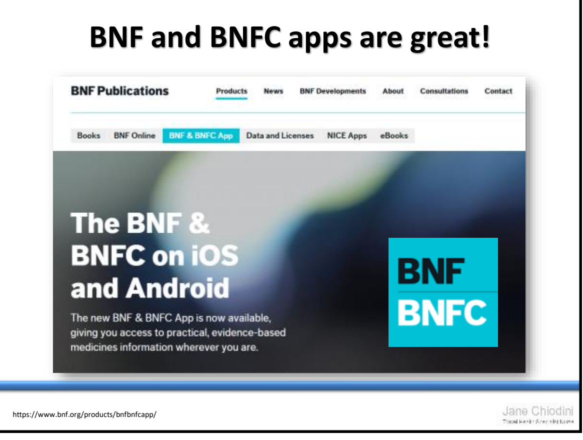

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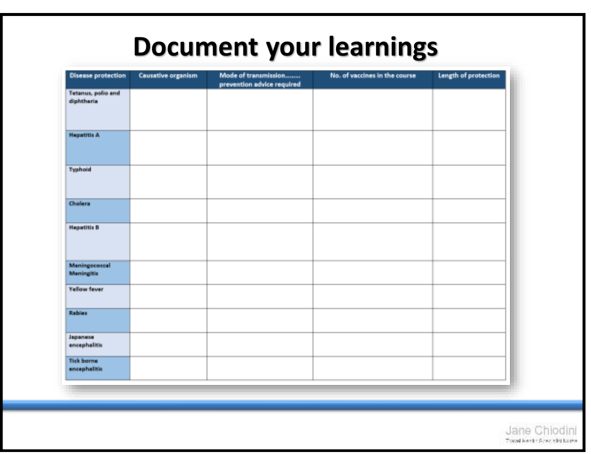

Disease protection	Causative organism	Mode of transmission........ prevention advice required	No. of vaccines in the course	Length of protection
Tetanus, polio and diphtheria				
Hepatitis A				
Typhoid				
Cholera				
Hepatitis B				
Meningococcal Meningitis				
Yellow fever				
Rabies				
Japanese encephalitis				
Tick borne encephalitis				

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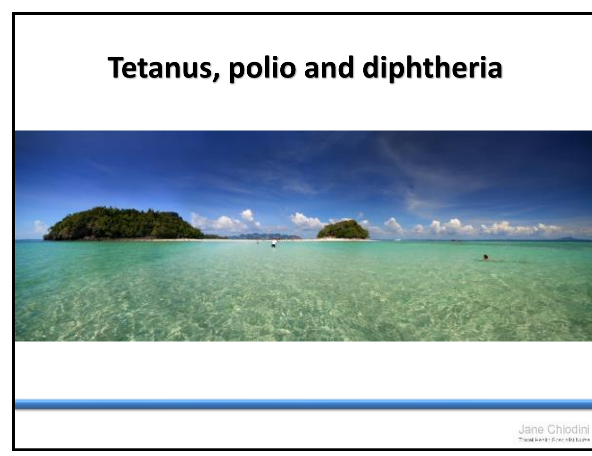

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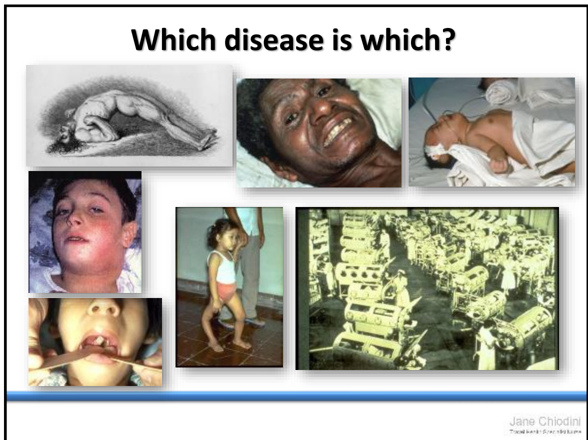

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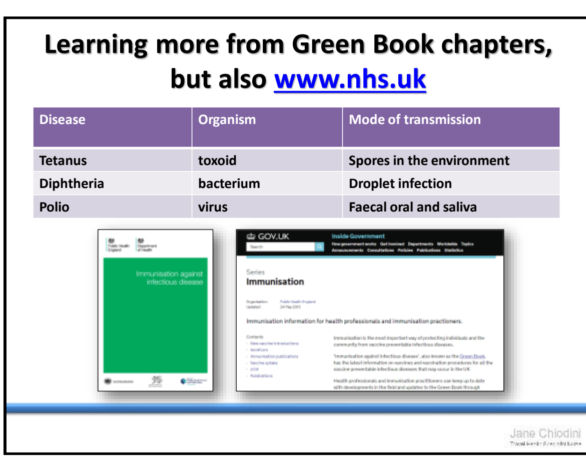

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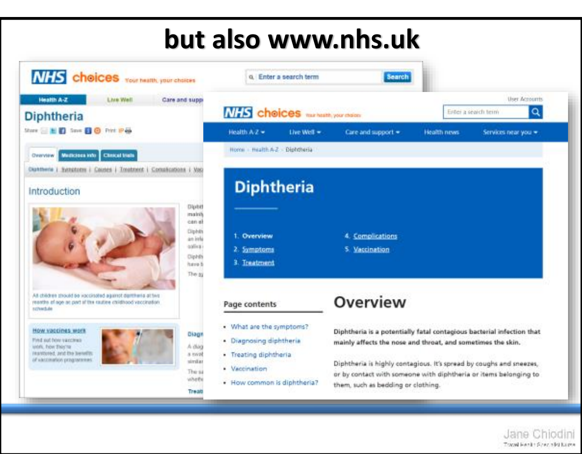

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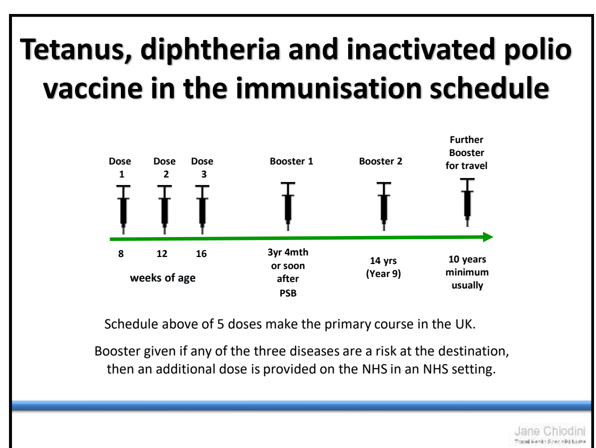

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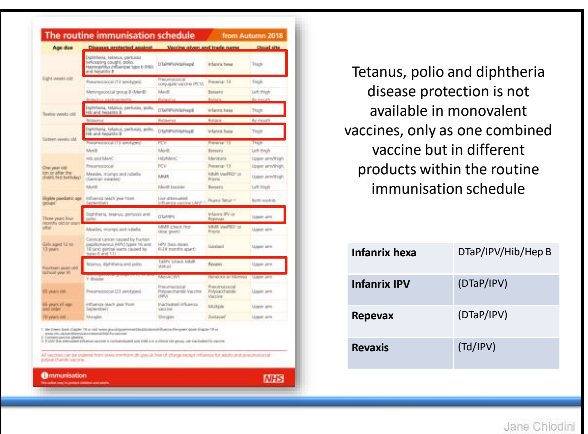

Tetanus, polio and diphtheria disease protection is not available in monovalent vaccines, only as one combined vaccine but in different products within the routine immunisation schedule

Infanrix hexa	DTaP/IPV/Hib/Hep B
Infanrix IPV	(DTaP/IPV)
Repevax	(DTaP/IPV)
Revaxis	(Td/IPV)

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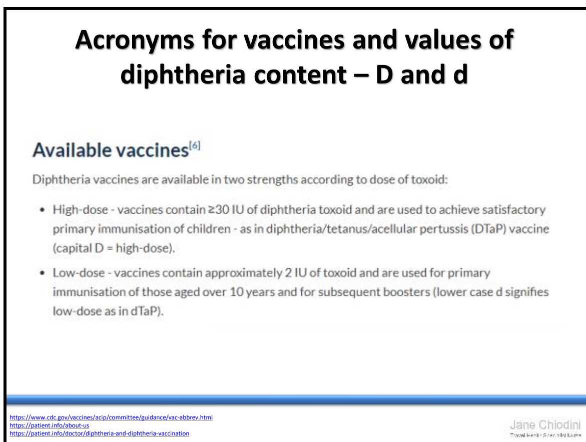
Acronyms for vaccines and values of diphtheria content – D and d



Available vaccines[6]

Diphtheria vaccines are available in two strengths according to dose of toxoid:

- High-dose - vaccines contain ≥30 IU of diphtheria toxoid and are used to achieve satisfactory primary immunisation of children - as in diphtheria/tetanus/acellular pertussis (DTaP) vaccine (capital D = high-dose).
- Low-dose - vaccines contain approximately 2 IU of toxoid and are used for primary immunisation of those aged over 10 years and for subsequent boosters (lower case d signifies low-dose as in dTaP).

https://www.cdc.gov/vaccines/acip/committee/guidance/vac-abbrev.html
https://patient.info/about-us
https://patient.info/doctor/diphtheria-and-diphtheria-vaccination

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Would this traveller need Td/IPV?

- Lucy is 19 years old and is going on a two week holiday in the Galapagos Islands
- She is up to date on all her scheduled national programme immunisations
- She hasn't travelled abroad before
- No PMH, she is on the OCP only

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Galapagos Islands off coast of Ecuador

Colombia
Ecuador

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Would this traveller need Td/IPV?

- James is 26 years old
- he's taking a one year career break back packing around the world
- He last had a tetanus vaccine as a school booster 9½ years ago at the age of 16

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Keeping an eye on other groups

TRAVEL HEALTH PRO

PUBLIC HEALTH ENGLAND UPDATES PERTUSSIS VACCINE ADVICE FOR PREGNANT WOMEN

Pertussis vaccine for pregnant women now recommended earlier

dTaP/IPV vaccine given between gestational weeks 20* and 32 rather than from week 28

*Can be given from 16 weeks but usually offered after the anomaly scan

Examples are ?

Boostrix-IPV or Repevax

To find out more about whole cell pertussis and acellular pertussis see http://www.who.int/biologicals/vaccines/pertussis/en/

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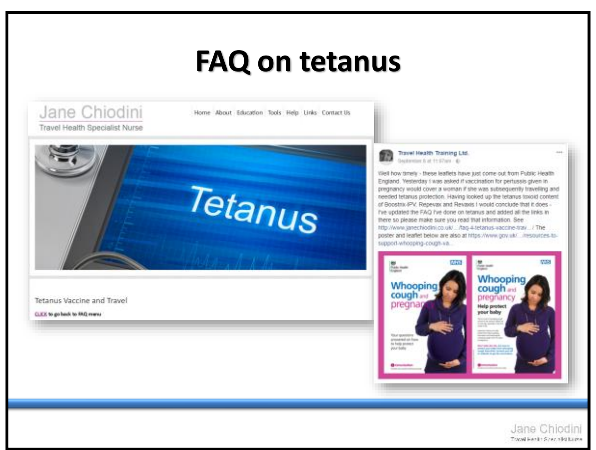

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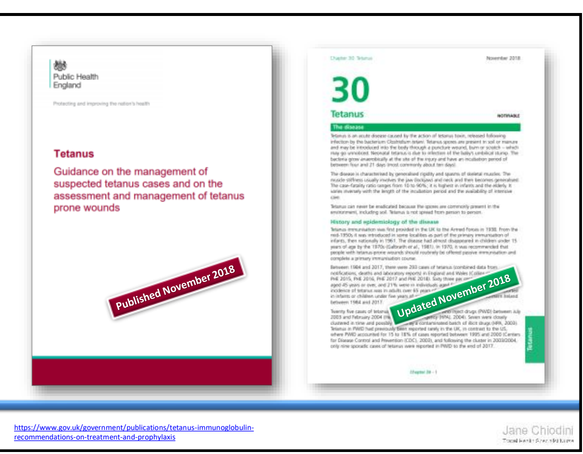

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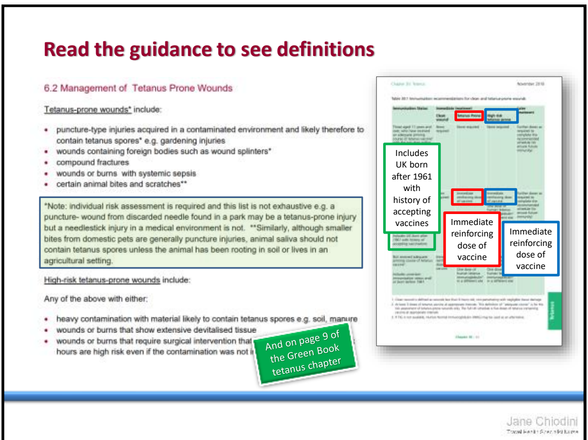

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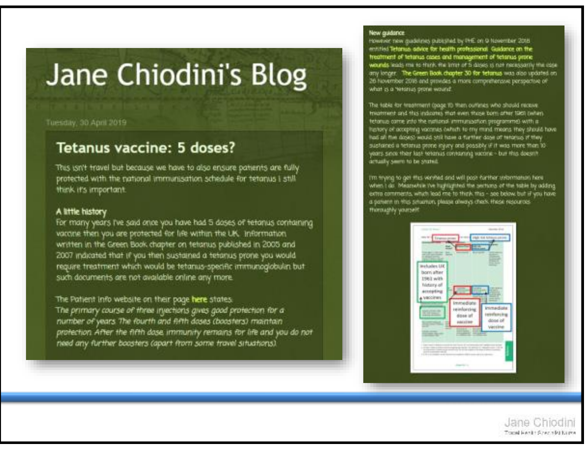

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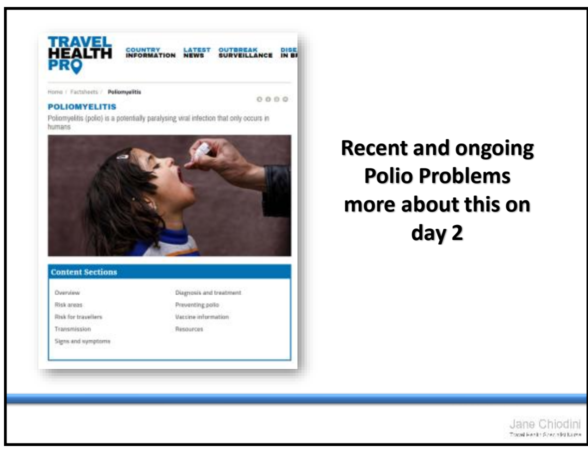

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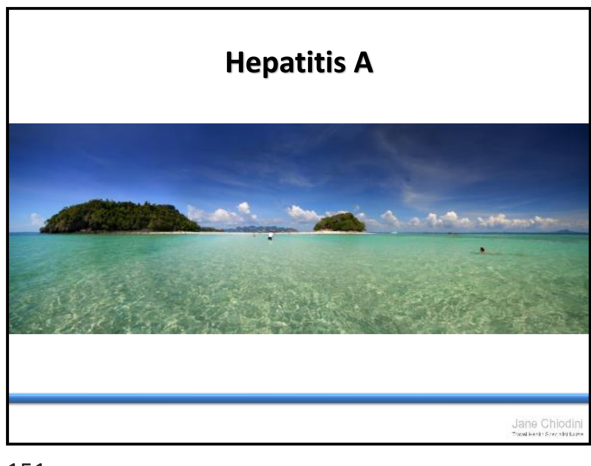

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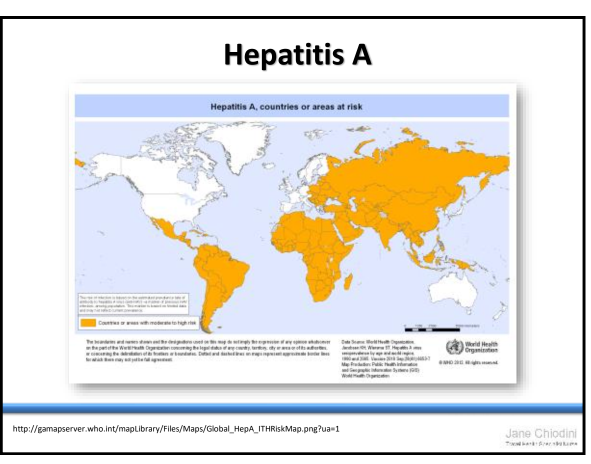

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Hepatitis A disease

- Viral infection
- Transmitted via contaminated food and water
- Those at higher risk – VFRs, long term travellers, those exposed to conditions of poor sanitation
- Incubation averages 28 - 30 days (range 15 to 50 days)
- Often asymptomatic in young children
- Abrupt onset of malaise, anorexia, nausea, fever followed by jaundice
- Fulminant hepatitis is more likely in those with pre-existing liver disease and in older individuals
- The overall case fatality ratio is low but is greater in older patients and those with pre-existing liver disease

http://phil.cdc.gov/phil/home.asp

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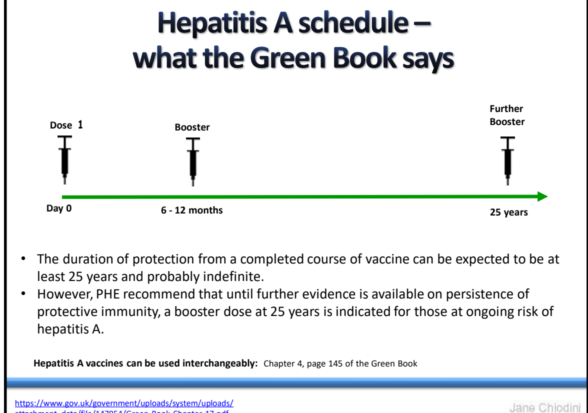

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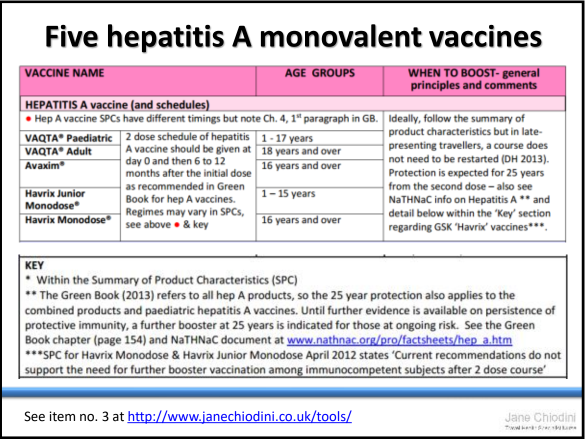

Five hepatitis A monovalent vaccines

VACCINE NAME		AGE GROUPS	WHEN TO BOOST- general principles and comments
HEPATITIS A vaccine (and schedules)			
• Hep A vaccine SPCs have different timings but note Ch. 4, 1st paragraph in GB.			Ideally, follow the summary of product characteristics but in late-presenting travellers, a course does not need to be restarted (DH 2013). Protection is expected for 25 years from the second dose – also see NaTHNaC info on Hepatitis A ** and detail below within the 'Key' section regarding GSK 'Havrix' vaccines***.
VAQTA® Paediatric	2 dose schedule of hepatitis A vaccine should be given at day 0 and then 6 to 12 months after the initial dose as recommended in Green Book for hep A vaccines. Regimes may vary in SPCs, see above • & key	1 - 17 years	
VAQTA® Adult		18 years and over	
Avaxim®		16 years and over	
Havrix Junior Monodose®		1 – 15 years	
Havrix Monodose®		16 years and over	

KEY
* Within the Summary of Product Characteristics (SPC)
** The Green Book (2013) refers to all hep A products, so the 25 year protection also applies to the combined products and paediatric hepatitis A vaccines. Until further evidence is available on persistence of protective immunity, a further booster at 25 years is indicated for those at ongoing risk. See the Green Book chapter (page 154) and NaTHNaC document at www.nathnac.org/pro/factsheets/hep_a.htm
***SPC for Havrix Monodose & Havrix Junior Monodose April 2012 states 'Current recommendations do not support the need for further booster vaccination among immunocompetent subjects after 2 dose course'

See item no. 3 at http://www.janechiodini.co.uk/tools/

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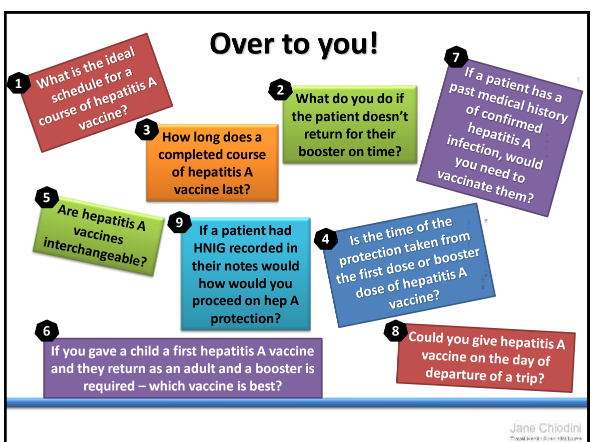

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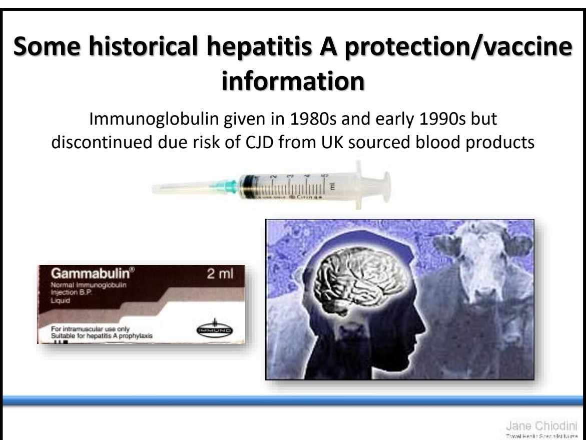
Some historical hepatitis A protection/vaccine information

Immunoglobulin given in 1980s and early 1990s but discontinued due risk of CJD from UK sourced blood products



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Some historical hepatitis A protection and vaccine information

- Immunoglobulin given in 1980s and early 1990s but discontinued due risk of CJD from UK sourced blood products
- Hepatitis A vaccine introduced in 1992 – Havrix – had to give two doses prior to travel as it had 720 ELISA units of hepatitis A (three doses in total course)
- Havrix Monodose available from 1994 which had 1440 ELISA units of hepatitis A and only one dose required prior to travel (two doses in total course)
- Vaqta Adult – problem in 1990s when some batches thought not to give protection – instructed at that time to disregard doses given previously and re-vaccinate. Vaqta Adult now available again
- See **Nuggets of Knowledge – hepatitis A**

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Would this traveller need hep A vaccine?

- Lucy is 19 years old and is going on a two week holiday in the Galapagos Islands
- She is up to date on all her scheduled national programme immunisations
- She hasn't travelled abroad before
- No PMH, she is on the OCP only
- Which vaccine schedule would you give?

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Would this traveller need hep A vaccine ?

- James is 26 years old
- he's taking a one year career break back packing around the world
- He last had a tetanus vaccine as a school booster 9½ years ago at the age of 16
- He tells you he had one dose of hep A vaccine when he was 12 years old but there is no record of it in the notes
- How would you proceed?

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Tip

Hepatitis A vaccine provides some of the most frequently asked questions therefore NaTHNaC and TRAVAX both have very helpful documents to help – it's a good idea to be aware of them

http://travelhealthpro.org.uk/hepatitis-a/

http://www.travax.nhs.uk/diseases/vaccine-preventable/hepatitis-a/hepatitis-a-faqs.aspx

FAQ on Hep A from TRAVAX

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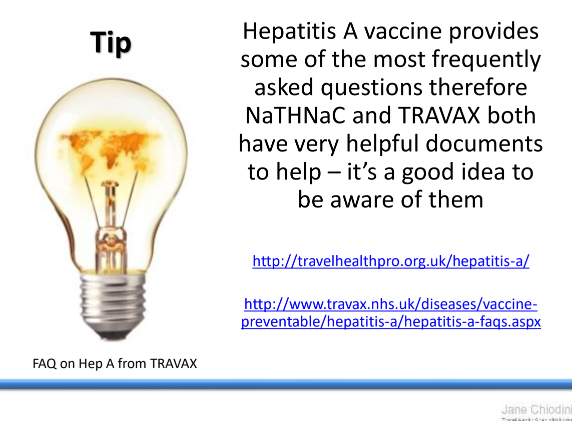

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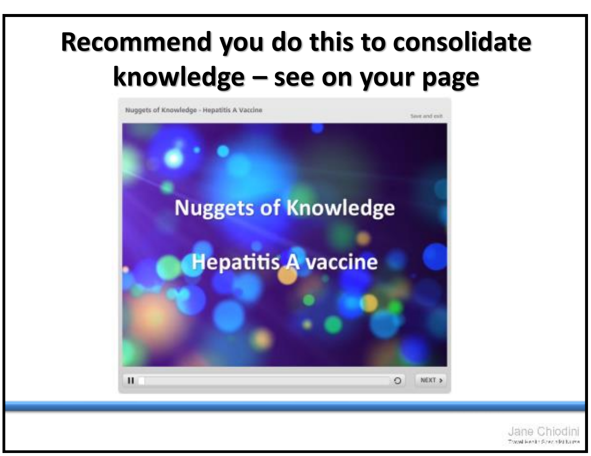

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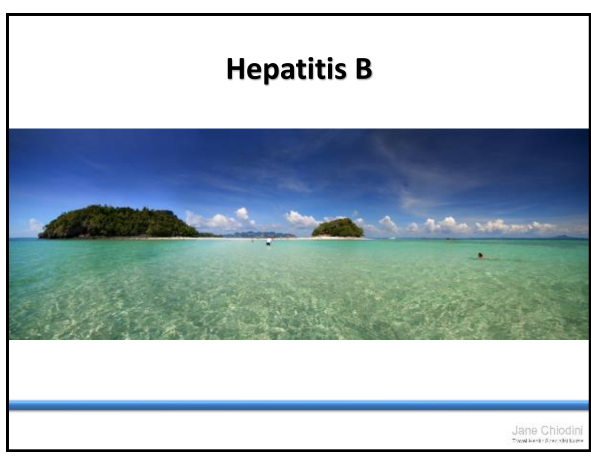

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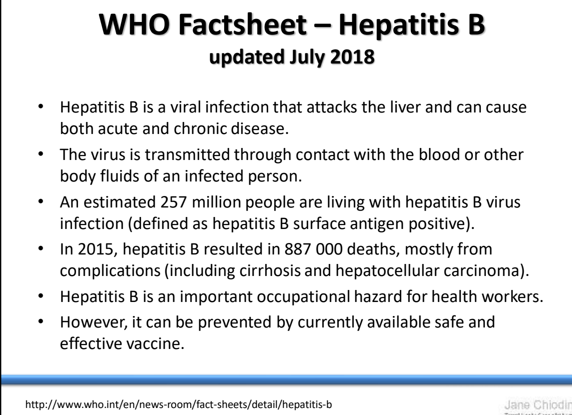

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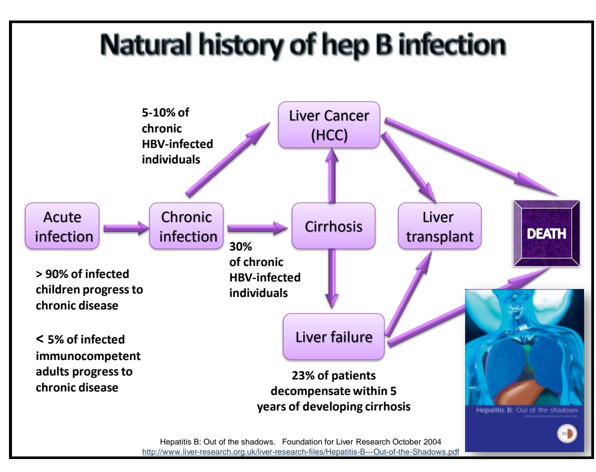

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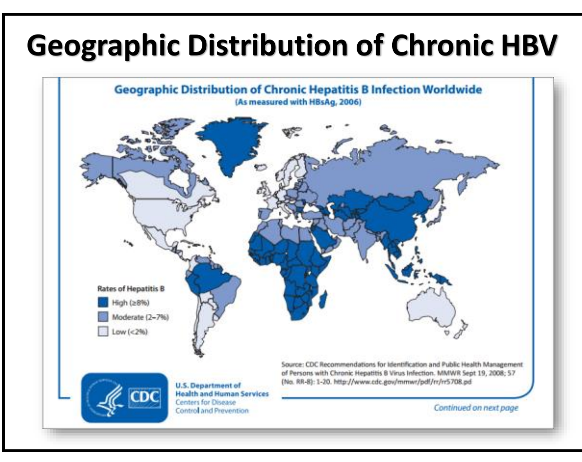

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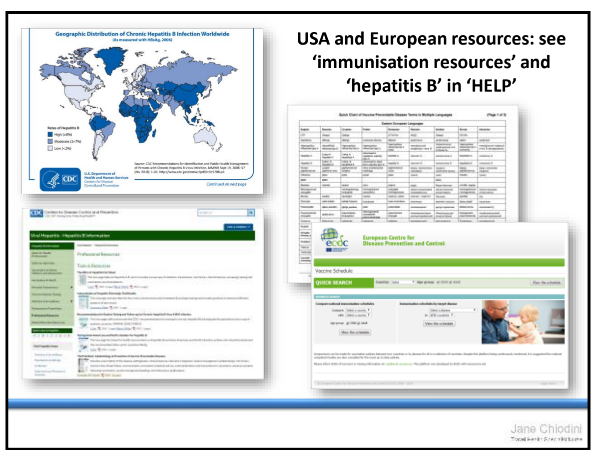

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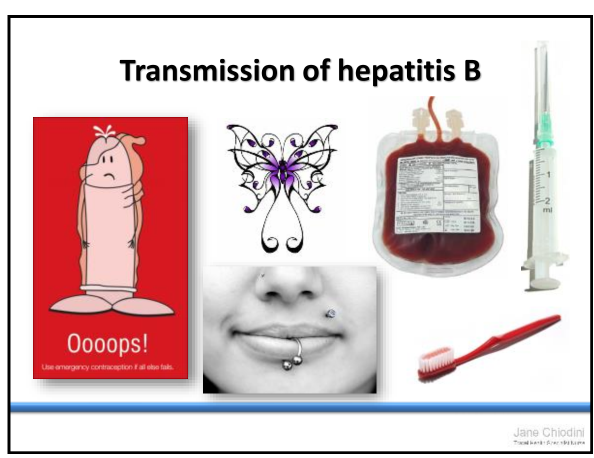

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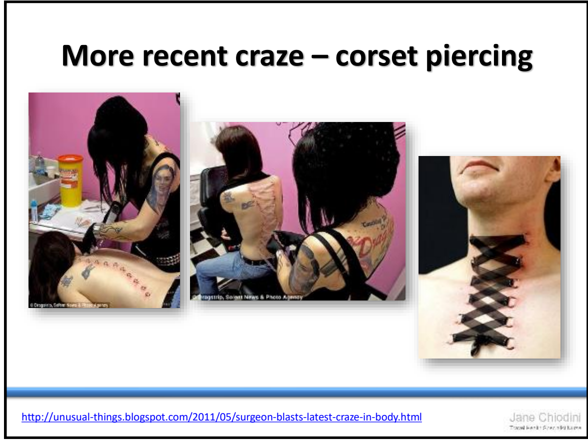

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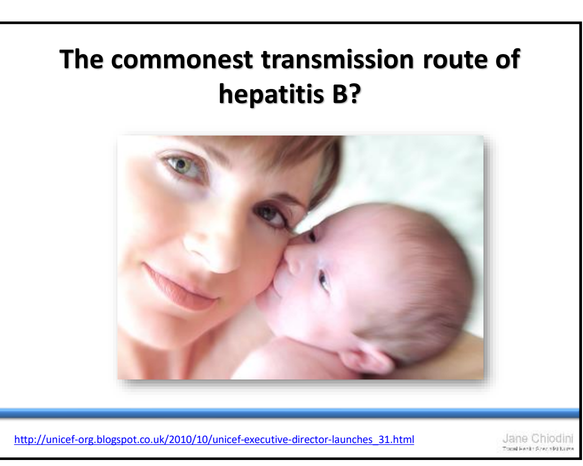

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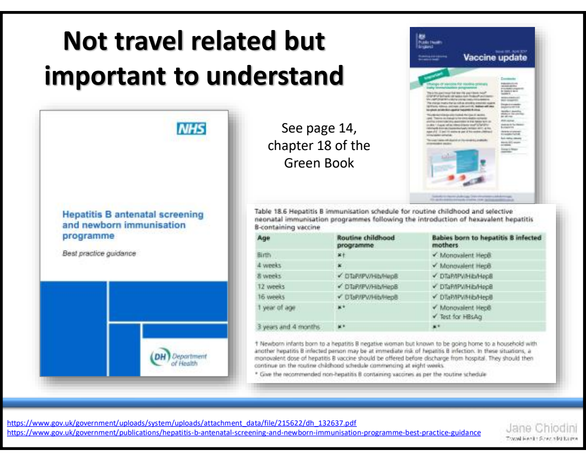

Table 18.6 Hepatitis B immunisation schedule for routine childhood and selective neonatal immunisation programmes following the introduction of hexavalent hepatitis B-containing vaccine

Age	Routine childhood programme	Babies born to hepatitis B infected mothers
Birth	✗†	✓ Monovalent HepB
4 weeks	✗	✓ Monovalent HepB
8 weeks	✓ DTaP/IPV/Hib/HepB	✓ DTaP/IPV/Hib/HepB
12 weeks	✓ DTaP/IPV/Hib/HepB	✓ DTaP/IPV/Hib/HepB
16 weeks	✓ DTaP/IPV/Hib/HepB	✓ DTaP/IPV/Hib/HepB
1 year of age	✗*	✓ Monovalent HepB ✓ Test for HBsAg
3 years and 4 months	✗*	✗*

† Newborn infants born to a hepatitis B negative woman but known to be going home to a household with another hepatitis B infected person may be at immediate risk of hepatitis B infection. In these situations, a monovalent dose of hepatitis B vaccine should be offered before discharge from hospital. They should then continue on the routine childhood schedule commencing at eight weeks.

* Give the recommended non-hepatitis B containing vaccines as per the routine schedule

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Green Book recommendations for hepatitis B vaccine

- Injecting drug users
- Individuals who change sexual partners frequently, particularly MSM and commercial sex workers
- Close family contacts of a case or carrier
- Families adopting children from countries with a high or intermediate prevalence of hepatitis B
- Foster carers
- Individuals receiving regular blood or blood products and their carers
- Patients with chronic renal failure
- Patients with chronic liver disease
- Inmates of custodial institutions
- Individuals in residential accomodation for those with learning dificulties

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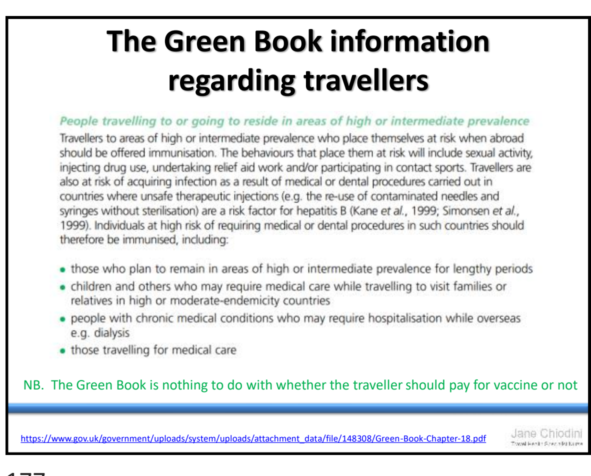

The Green Book information regarding travellers

People travelling to or going to reside in areas of high or intermediate prevalence

Travellers to areas of high or intermediate prevalence who place themselves at risk when abroad should be offered immunisation. The behaviours that place them at risk will include sexual activity, injecting drug use, undertaking relief aid work and/or participating in contact sports. Travellers are also at risk of acquiring infection as a result of medical or dental procedures carried out in countries where unsafe therapeutic injections (e.g. the re-use of contaminated needles and syringes without sterilisation) are a risk factor for hepatitis B (Kane *et al.*, 1999; Simonsen *et al.*, 1999). Individuals at high risk of requiring medical or dental procedures in such countries should therefore be immunised, including:

- those who plan to remain in areas of high or intermediate prevalence for lengthy periods
- children and others who may require medical care while travelling to visit families or relatives in high or moderate-endemicity countries
- people with chronic medical conditions who may require hospitalisation while overseas e.g. dialysis
- those travelling for medical care

NB. The Green Book is nothing to do with whether the traveller should pay for vaccine or not

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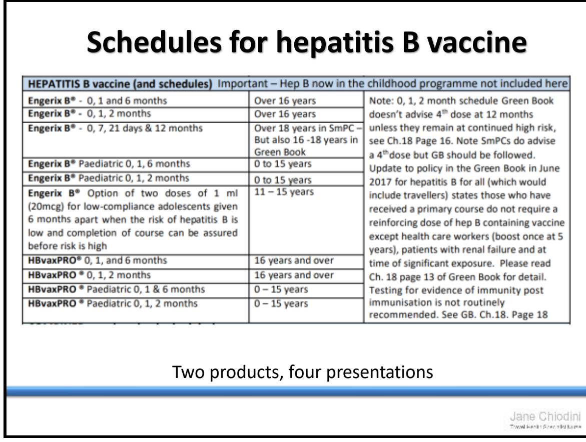

Schedules for hepatitis B vaccine

HEPATITIS B vaccine (and schedules)	Important – Hep B now in the childhood programme not included here	
Engerix B® - 0, 1 and 6 months	Over 16 years	Note: 0, 1, 2 month schedule Green Book doesn't advise 4th dose at 12 months unless they remain at continued high risk, see Ch.18 Page 16. Note SmPCs do advise a 4th dose but GB should be followed. Update to policy in the Green Book in June 2017 for hepatitis B for all (which would include travellers) states those who have received a primary course do not require a reinforcing dose of hep B containing vaccine except health care workers (boost once at 5 years), patients with renal failure and at time of significant exposure. Please read Ch. 18 page 13 of Green Book for detail. Testing for evidence of immunity post immunisation is not routinely recommended. See GB. Ch.18. Page 18
Engerix B® - 0, 1, 2 months	Over 16 years	
Engerix B® - 0, 7, 21 days & 12 months	Over 18 years in SmPC – But also 16 -18 years in Green Book	
Engerix B® Paediatric 0, 1, 6 months	0 to 15 years	
Engerix B® Paediatric 0, 1, 2 months	0 to 15 years	
Engerix B® Option of two doses of 1 ml (20mcg) for low-compliance adolescents given 6 months apart when the risk of hepatitis B is low and completion of course can be assured before risk is high	11 – 15 years	
HBvaxPRO® 0, 1, and 6 months	16 years and over	
HBvaxPRO ® 0, 1, 2 months	16 years and over	
HBvaxPRO ® Paediatric 0, 1 & 6 months	0 – 15 years	
HBvaxPRO ® Paediatric 0, 1, 2 months	0 – 15 years	

Two products, four presentations

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Which schedule?

Hepatitis B Green Book chapter page 12

Pre-exposure immunisation schedule for high risk individuals

- For pre-exposure prophylaxis in most adult and childhood risk groups, an accelerated schedule should be used, with vaccine given at zero, one and two months.
- Higher completion rates are achieved with the accelerated schedule (at zero, one and two months) in groups where compliance is difficult (e.g. in people who inject drugs [PWID] and genitourinary medicine clinic attenders) (Asboe et al., 1996).
- This improved compliance is likely to offset the slightly reduced immunogenicity when compared with the zero-, one- and six-month schedule, and similar response rates can be achieved by the opportunistic use of a fourth dose after 12 months.
- An alternative schedule at zero, one and six months should only be used where rapid protection is not required and there is a high likelihood of compliance.
- If the primary course is interrupted it should be resumed but not repeated.)

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What about hepatitis B boosters?

Hepatitis B Green Book chapter page 13

Reinforcing doses for those who have received pre-exposure immunisation

The current UK recommendation is that those who have received a primary course of immunisation, including children vaccinated according to the routine childhood schedule and individuals at high risk of exposure, **do not require a reinforcing dose of Hep B-containing vaccine**, except in the following categories:

- healthcare workers (including students and trainees), who should be offered a single booster dose of vaccine, once only, around five years after primary immunisation
- patients with renal failure
- at the time of a significant exposure (see the chapter for more detail)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/628602/Greenbook_chapter__18.pdf

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Public Health England

Plan for phased re-introduction of hepatitis B vaccine for lower priority groups in 2018

Statement in this guidance Feb 2018

– not yet in the Green Book

Booster doses in healthcare workers

On the advice of the Joint Committee on Vaccination and Immunisation (JCVI), boosters (priority group 5) will no longer be routinely required in healthy, immunocompetent adults who have completed a primary course of vaccine, including healthcare workers who are known responders.

See page 8

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/683830/Plan_for_phased_re-introduction_of_hepatitis_B_vaccine_for_lower_priority_groups_2018_.pdf

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In summary for hepatitis B vaccine given for travel purposes

HBV Vaccine

- **Use 0, 1 and 2 month schedule in preference to 0, 1 and 6 month when more rapid protection is needed**
- **If insufficient time before travel, use a 0, 7, 21 day and then reinforce at 12 months**
- **No longer boost at 5 years for travel**
- **Blood test not routinely performed for seroprotection in travellers**

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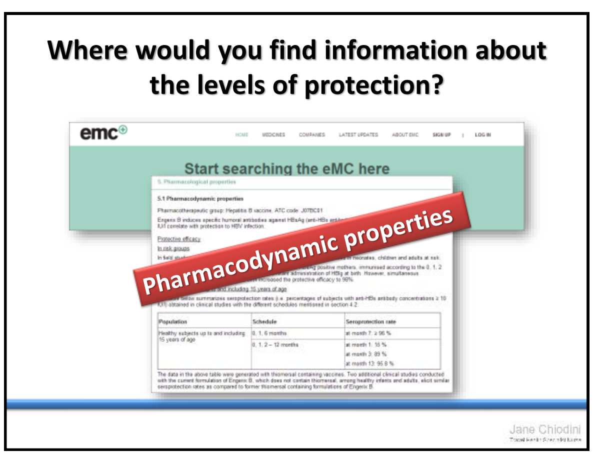

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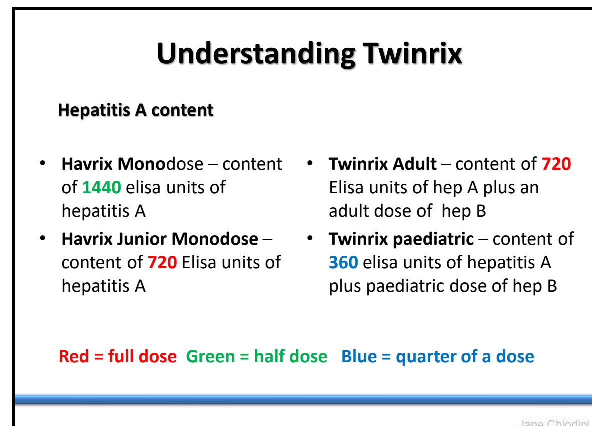

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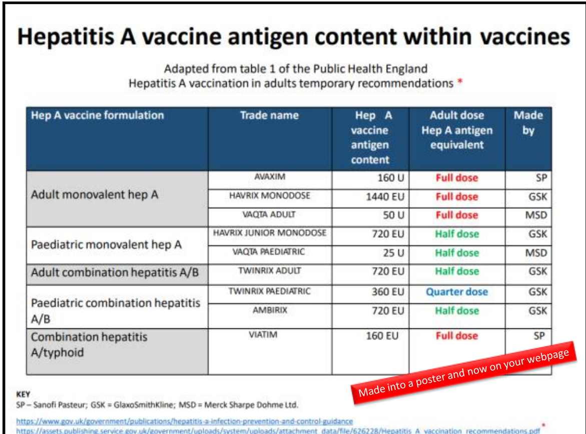

Hepatitis A vaccine antigen content within vaccines

Adapted from table 1 of the Public Health England
Hepatitis A vaccination in adults temporary recommendations *

Hep A vaccine formulation	Trade name	Hep A vaccine antigen content	Adult dose Hep A antigen equivalent	Made by
Adult monovalent hep A	AVAXIM	160 U	Full dose	SP
	HAVRIX MONODOSE	1440 EU	Full dose	GSK
	VAQTA ADULT	50 U	Full dose	MSD
Paediatric monovalent hep A	HAVRIX JUNIOR MONODOSE	720 EU	Half dose	GSK
	VAQTA PAEDIATRIC	25 U	Half dose	MSD
Adult combination hepatitis A/B	TWINRIX ADULT	720 EU	Half dose	GSK
Paediatric combination hepatitis A/B	TWINRIX PAEDIATRIC	360 EU	Quarter dose	GSK
	AMBIRIX	720 EU	Half dose	GSK
Combination hepatitis A/typhoid	VIATIM	160 EU	Full dose	SP

Made into a poster and now on your webpage

KEY
SP – Sanofi Pasteur; GSK = GlaxoSmithKline; MSD = Merck Sharpe Dohme Ltd.

https://www.gov.uk/government/publications/hepatitis-a-infection-prevention-and-control-guidance
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/626228/Hepatitis_A_vaccination_recommendations.pdf *

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Explaining composition of Twinrix

half a dose of hep A — Ist twinrix vaccine

+

half a dose of hep A — 2nd twinrix vaccine

⇒ full dose of hep A — Full Hepatitis A protection

Two doses of Twinrix (adult or paediatric) must be given to achieve protection against hepatitis A prior to departure

RULE – if you start with Twinrix you can complete with Twinrix. If you start with monovalent vaccines DON'T try to complete with Twinrix

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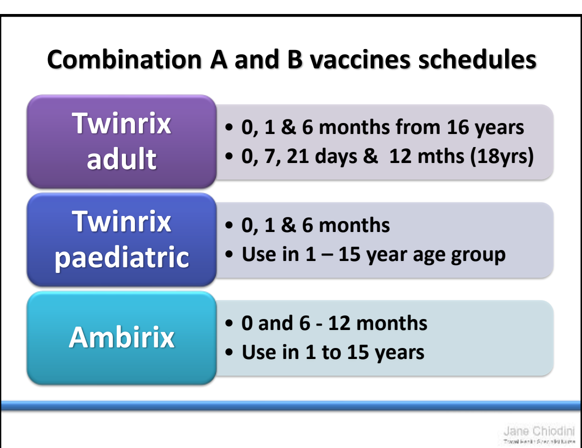

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Understanding content of Twinrix and Ambirix

- **Havrix Monodose** – content of 1440 elisa units of hepatitis A
- **Havrix Junior Monodose** – content of 720 Elisa units of hepatitis A
- **Twinrix Adult** – content of 720 Elisa units of hep A plus an adult dose of hep B
- **Twinrix paediatric** – content of 360 elisa units of hepatitis A plus paediatric dose of hep B

Ambirix – content of 720 elisa units of hepatitis A plus a full dose of hep B

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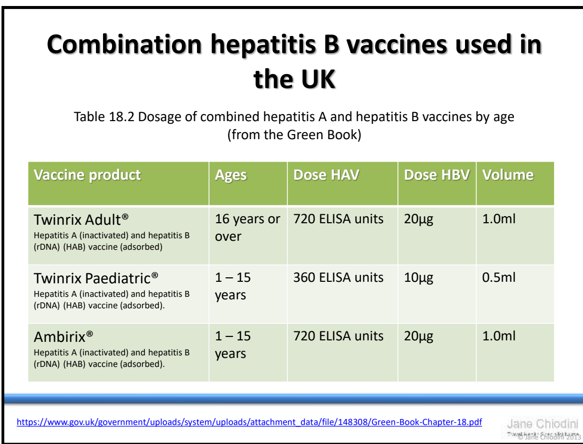

Combination hepatitis B vaccines used in the UK

Table 18.2 Dosage of combined hepatitis A and hepatitis B vaccines by age (from the Green Book)

Vaccine product	Ages	Dose HAV	Dose HBV	Volume
Twinrix Adult® Hepatitis A (inactivated) and hepatitis B (rDNA) (HAB) vaccine (adsorbed)	16 years or over	720 ELISA units	20µg	1.0ml
Twinrix Paediatric® Hepatitis A (inactivated) and hepatitis B (rDNA) (HAB) vaccine (adsorbed).	1 – 15 years	360 ELISA units	10µg	0.5ml
Ambirix® Hepatitis A (inactivated) and hepatitis B (rDNA) (HAB) vaccine (adsorbed).	1 – 15 years	720 ELISA units	20µg	1.0ml

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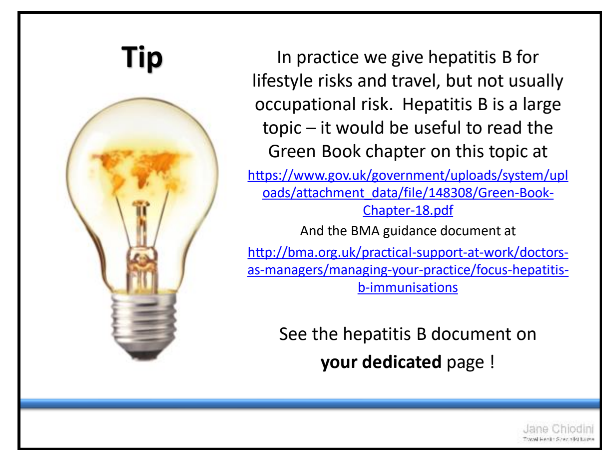

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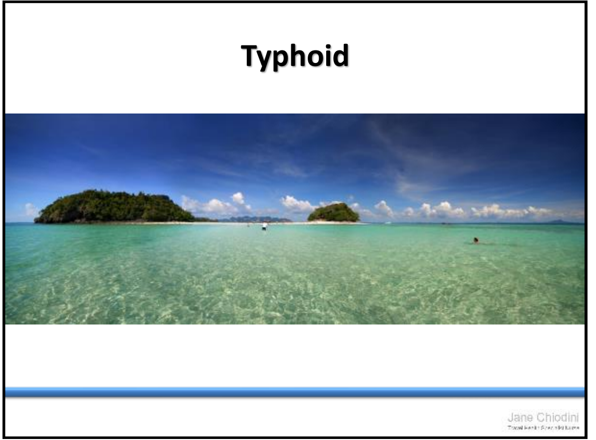

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Enteric fevers – typhoid & paratyphoid

- Gram-negative bacterial infection
- Transmission by faecal-oral route, water borne and human to human
- Those at higher risk include VFRs, young children, long term travellers and those exposed to conditions of poor sanitation – mainly in Asia
- Incubation 7 to 14 days
- Fever, chills, headache, malaise, weakness, anorexia, abdominal pain, diarrhoea
- Complications in 10% -15%: intestinal perforation, bacteraemia, meningitis
- Chronic carrier status in <3% infected persons

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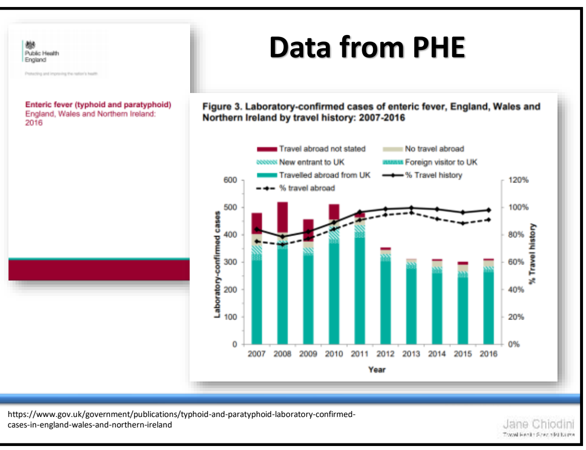

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Reason for travel and destination

Figure 4. Reason for travel for laboratory-confirmed cases of enteric fever that travelled abroad from England, Wales and Northern Ireland: 2016 (N=265)

198, 75%; 40, 15%; 8, 3%

VFR · Holiday · Business

Where reason for travel was known (N=248), th… cases that travelled abroad from EWNI was to v…

India, Pakistan and Bangladesh were the highest risk country for travellers returning with enteric fever

Table 3. Countries of travel and ethnicity for laboratory-confirmed cases of enteric fever that travelled abroad from England, Wales and Northern Ireland to visit friends and relatives: 2016 (N=198*)

	Ethnicity							
Presumed country of infection	Pakistani	Indian	Bangladeshi	Asian other	Black African	Other/mixed	Not stated	Total
Pakistan	75	2	-	1	-	-	4	82
India	-	87	-	-	-	-	6	93
Bangladesh	-	-	12	-	-	-	-	12
Sub-Saharan Africa	-	-	-	-	2	1	1	4
South America	-	-	-	-	-	1	-	1
Europe	-	-	-	-	-	1	-	1
Other Asia	-	3	-	3	-	-	1	7
Total	75	92	12	4	2	3	12	200*

* Note that some cases travelled to more than one country; all countries are included in this table so the totals in the table will be higher than the actual number of cases.

https://www.gov.uk/government/publications/typhoid-and-paratyphoid-laboratory-confirmed-cases-in-england-wales-and-northern-ireland

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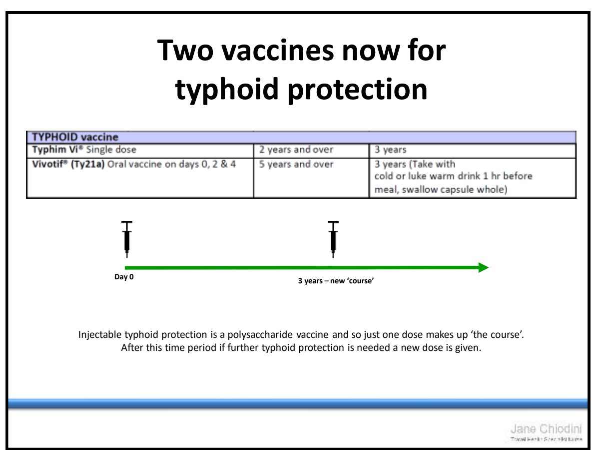

TYPHOID vaccine		
Typhim Vi® Single dose	2 years and over	3 years
Vivotif® (Ty21a) Oral vaccine on days 0, 2 & 4	5 years and over	3 years (Take with cold or luke warm drink 1 hr before meal, swallow capsule whole)

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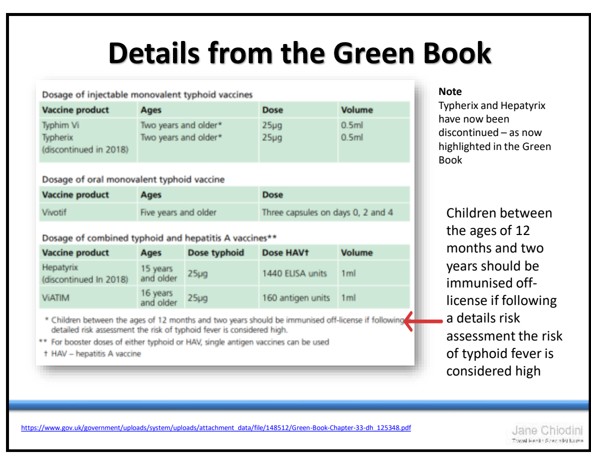

Dosage of injectable monovalent typhoid vaccines

Vaccine product	Ages	Dose	Volume
Typhim Vi	Two years and older*	25µg	0.5ml
Typherix (discontinued in 2018)	Two years and older*	25µg	0.5ml

Dosage of oral monovalent typhoid vaccine

Vaccine product	Ages	Dose
Vivotif	Five years and older	Three capsules on days 0, 2 and 4

Dosage of combined typhoid and hepatitis A vaccines**

Vaccine product	Ages	Dose typhoid	Dose HAV†	Volume
Hepatyrix (discontinued In 2018)	15 years and older	25µg	1440 ELISA units	1ml
ViATIM	16 years and older	25µg	160 antigen units	1ml

* Children between the ages of 12 months and two years should be immunised off-license if following detailed risk assessment the risk of typhoid fever is considered high.
** For booster doses of either typhoid or HAV, single antigen vaccines can be used
† HAV – hepatitis A vaccine

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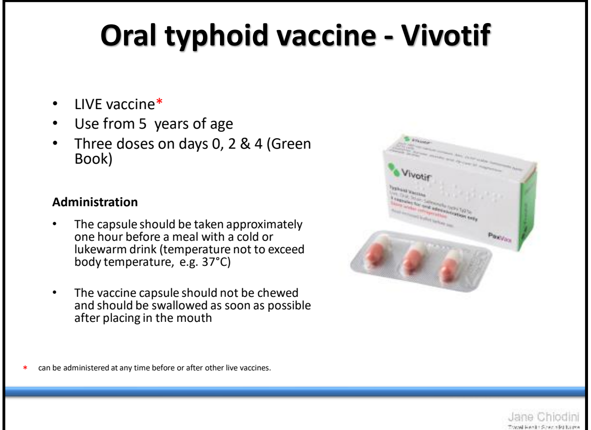

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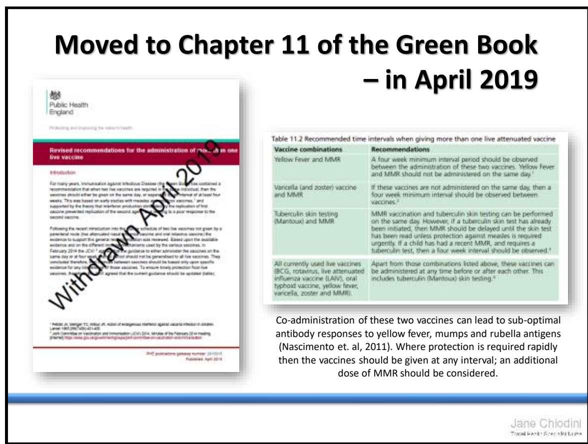

Table 11.2 Recommended time intervals when giving more than one live attenuated vaccine

Vaccine combinations	Recommendations
Yellow Fever and MMR	A four week minimum interval period should be observed between the administration of these two vaccines. Yellow Fever and MMR should not be administered on the same day.[1]
Varicella (and zoster) vaccine and MMR	If these vaccines are not administered on the same day, then a four week minimum interval should be observed between vaccines.[2]
Tuberculin skin testing (Mantoux) and MMR	MMR vaccination and tuberculin skin testing can be performed on the same day. However, if a tuberculin skin test has already been initiated, then MMR should be delayed until the skin test has been read unless protection against measles is required urgently. If a child has had a recent MMR, and requires a tuberculin test, then a four week interval should be observed.[3]
All currently used live vaccines (BCG, rotavirus, live attenuated influenza vaccine (LAIV), oral typhoid vaccine, yellow fever, varicella, zoster and MMR).	Apart from those combinations listed above, these vaccines can be administered at any time before or after each other. This includes tuberculin (Mantoux) skin testing.[4]

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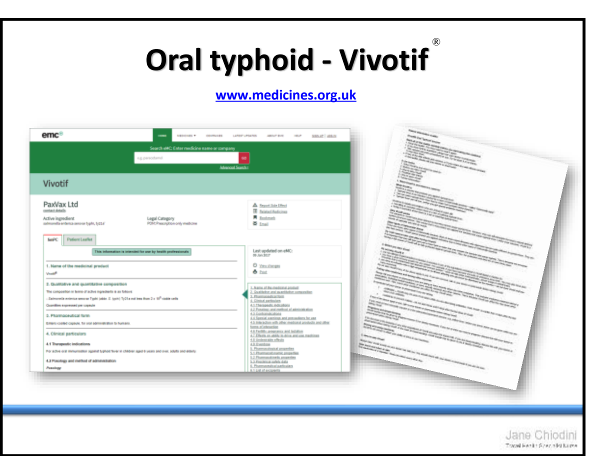

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Interactions with other medication from the SmPC

- Antibiotics – Vivotif may not work if it is taken while you are also taking antibiotics. Take Vivotif no earlier than 3 days after the last dose of an antibiotic
- Medicines to prevent malaria – do not start these until 3 days after the last dose of Vivotif
- Yellow fever vaccine can be given while taking Vivotif

Vivotif® Patient Information Leaflet http://www.medicines.org.uk/EMC/medicine/24328/PIL/Vivotif/

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Charging and administration

Oral typhoid vaccine is an NHS provision in an NHS setting

1. You could buy this vaccine in and bring the patient in for all three doses
2. You could administer the vaccine to the patient for the first dose and given them the other two doses to take home to self administer but the vaccine must be stored at 2 – 8°C
3. You could supply the vaccine on an FP10 and allow the patient to self administer

You need to ensure that your traveller understands the importance of, and can assure the cold chain in points 2 and 3 above.

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Who would need typhoid vaccine if there is a shortage?

- Family of four going to an all inclusive break for a 10 days Cancun
- 40 year old couple travelling to stay in 4 star hotel in Bangkok for two weeks
- 26 year old man going to stay in Bangkok in a guest house/hostel type accommodation and he has type 1 diabetes
- Parents and their children of 7, 5 and 2 years travelling to Pakistan for 3 weeks to see family

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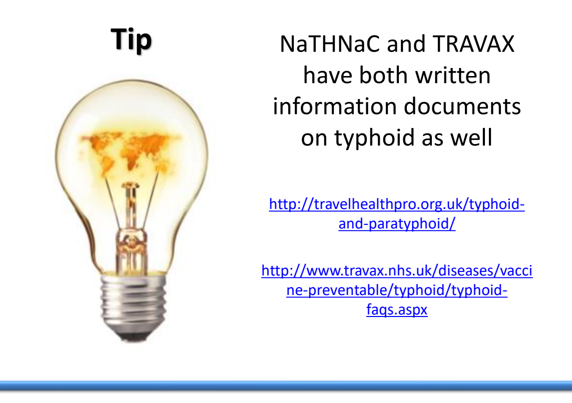
Tip



NaTHNaC and TRAVAX have both written information documents on typhoid as well

http://travelhealthpro.org.uk/typhoid-and-paratyphoid/

http://www.travax.nhs.uk/diseases/vaccine-preventable/typhoid/typhoid-faqs.aspx

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Hepatitis A + Typhoid available as a combined vaccine

Why give combination vaccines?

COMBINED vaccines (and schedules)		
VIATIM® (Hepatitis A and typhoid) Single dose	16 years and over	6-12 months for hepatitis A component (then hepatitis A booster given as a monovalent vaccine) and 3 years for the typhoid component

The combination hepatitis A and typhoid vaccine can be given with the hep A protection provided as either the first dose or reinforcing or booster dose of hep A vaccine as long as there is the three year interval to fulfill the typhoid requirement of the vaccine.

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Does this traveller need typhoid vaccine ?

Anu is travelling to Mumbai to see relatives for a 4 week stay – she is 22 years old. She had a 1st dose hepatitis A vaccine at the age of 14 years. Would she need a typhoid vaccine and which one would you give if so?

Anu needs a booster dose of hepatitis A vaccine and she needs a typhoid vaccine so it would be very appropriate in this situation to give her a combined hepatitis A and typhoid vaccine.

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TRAVEL HEALTH PRO

EXTENSIVELY DRUG-RESISTANT TYPHOID FEVER IN PAKISTAN

UNSAFE WATER DO NOT DRINK

Food and water hygiene advice remain paramount

https://travelhealthpro.org.uk/news/349/extensively-drug-resistant-typhoid-fever-in-pakistan

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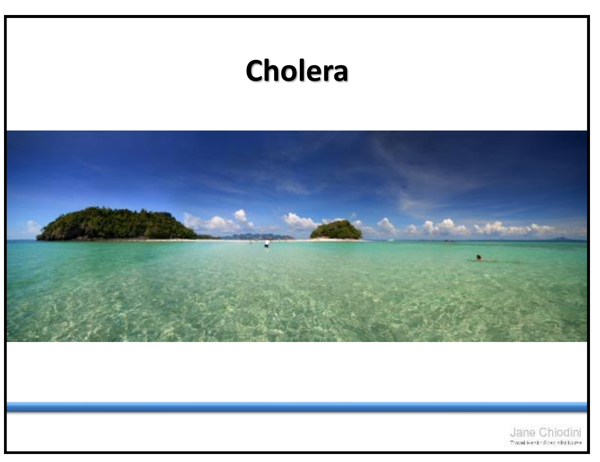

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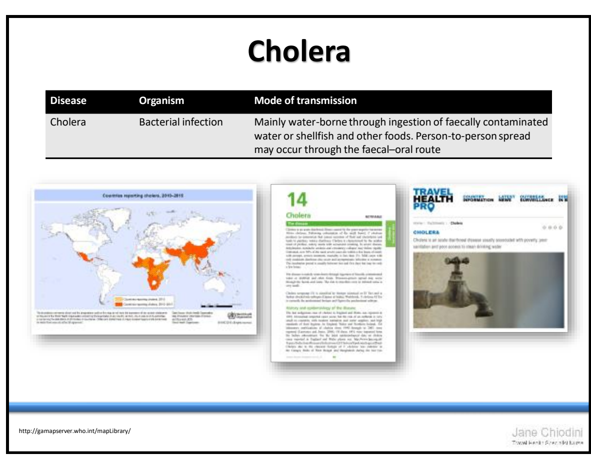

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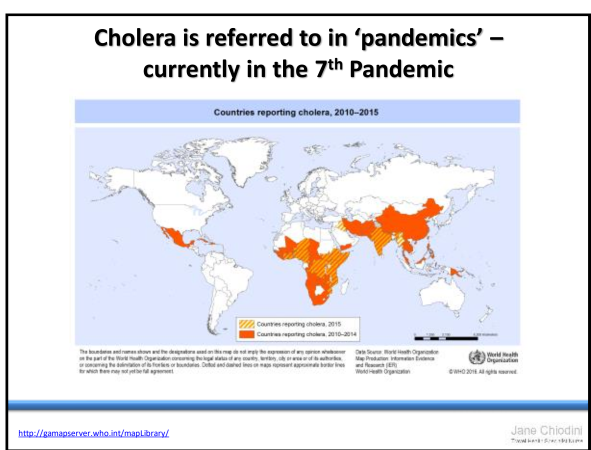

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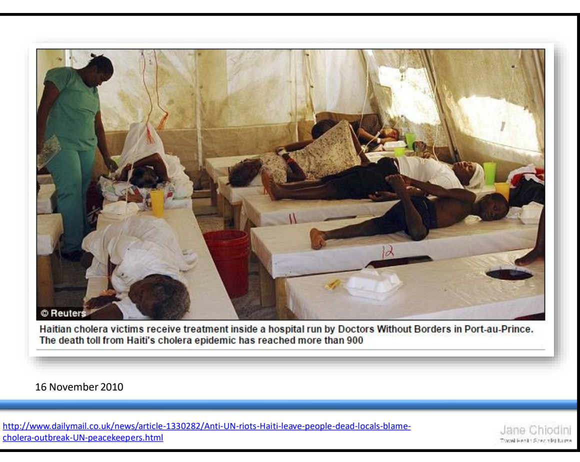

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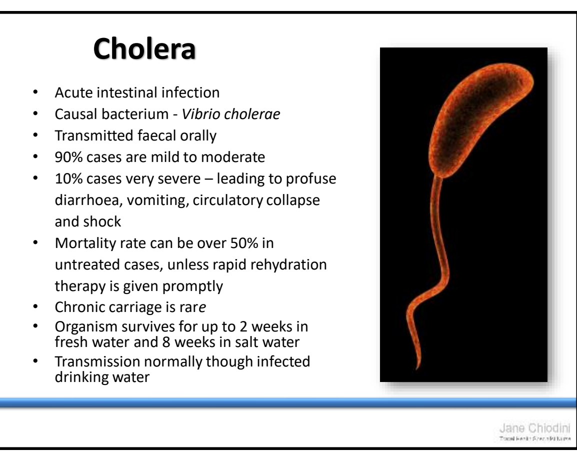

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Management of cholera

- Fluid replacement
- Prompt action improves outcome
- IV fluids in severe cases or when vomiting
- Rapid rehydration until signs improve
- NG tube used if IV not possible
- Antibiotic therapy in severe cases

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Cholera recommendations for administration

Advice from the Green Book

- Immunisation against cholera can be considered, following a full risk assessment, for the following categories of traveller:
  - relief or disaster aid workers
  - persons with remote itineraries in areas where cholera epidemics are occurring and there is limited access to medical care
  - **travellers to potential cholera risk areas, for whom vaccination is considered potentially beneficial**.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263838/Green-Book-Chapter-14v2_0.pdf

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Cholera vaccine fact finding

- What is the youngest age at which give cholera vaccine can be prescribed?
- How many doses would you give a child?
- How many doses would you give an adult?
- What is the minimum and maximum time interval between doses?
- How long does cholera vaccine last?

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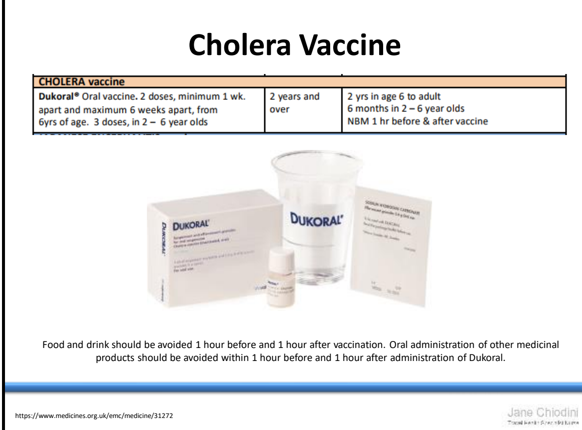
Cholera Vaccine



CHOLERA vaccine		
Dukoral® Oral vaccine. 2 doses, minimum 1 wk. apart and maximum 6 weeks apart, from 6yrs of age. 3 doses, in 2 – 6 year olds	2 years and over	2 yrs in age 6 to adult 6 months in 2 – 6 year olds NBM 1 hr before & after vaccine

Food and drink should be avoided 1 hour before and 1 hour after vaccination. Oral administration of other medicinal products should be avoided within 1 hour before and 1 hour after administration of Dukoral.

https://www.medicines.org.uk/emc/medicine/31272

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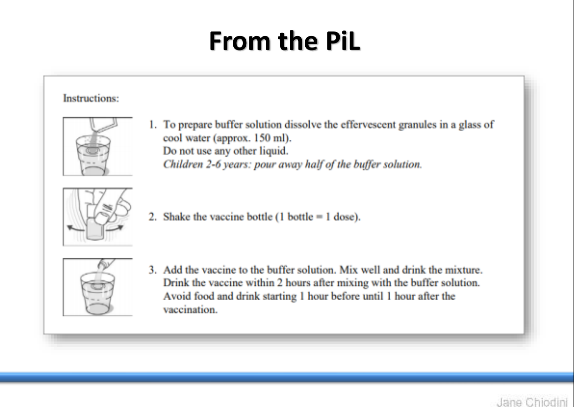
From the PiL



Instructions:

1. To prepare buffer solution dissolve the effervescent granules in a glass of cool water (approx. 150 ml).
   Do not use any other liquid.
   Children 2-6 years: pour away half of the buffer solution.
2. Shake the vaccine bottle (1 bottle = 1 dose).
3. Add the vaccine to the buffer solution. Mix well and drink the mixture. Drink the vaccine within 2 hours after mixing with the buffer solution. Avoid food and drink starting 1 hour before until 1 hour after the vaccination.

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Charging and administration

Cholera vaccine is an NHS provision in an NHS setting

1. You could buy this vaccine in and bring the patient in for subsequent doses
2. You could administer the vaccine to the patient for the first dose and given them the 2nd dose to take home to self administer but the vaccine must be stored at 2 – 8°C
3. You could supply the vaccine on an FP10 and allow the patient to self administer

You need to ensure that your traveller understands the importance of, and can assure the cold chain in points 2 and 3 above.

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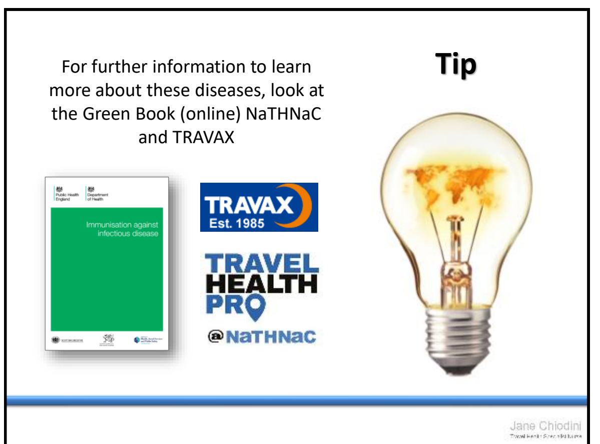

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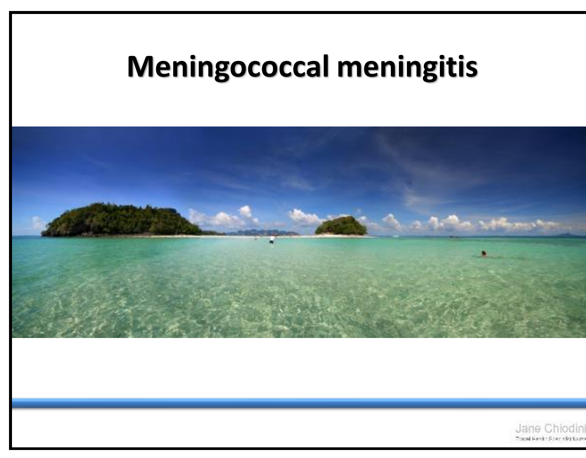

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Meningococcal Meningitis

- Meningococcal disease is a rare, but potentially devastating infection
- Caused by the bacteria *Neisseria meningitidis* of which there are 6 disease-causing strains called serogroups (A, B, C, W, Y and X)
- Approximately 10 percent of the general population of the UK are thought to carry *N. meningitidis* in the lining of the nose and throat
- Spread between individuals occurs through coughing, sneezing, kissing or during close contact with a carrier
- Carriers do not have symptoms, but can develop disease when bacteria invade the bloodstream from the nasopharynx
- Invasive disease is a rare but serious outcome usually presenting as septicaemia or meningitis

http://travelhealthpro.org.uk/diseases/meningococcalmeningitis/

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Meningococcal Meningitis

- Less commonly, individuals may present with pneumonia, myocarditis, endocarditis, pericarditis, arthritis, conjunctivitis, urethritis, pharyngitis and cervicitis
- The incubation period is from two to seven day

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223749/Green_Book_Chapter_22_v2_3.pdf

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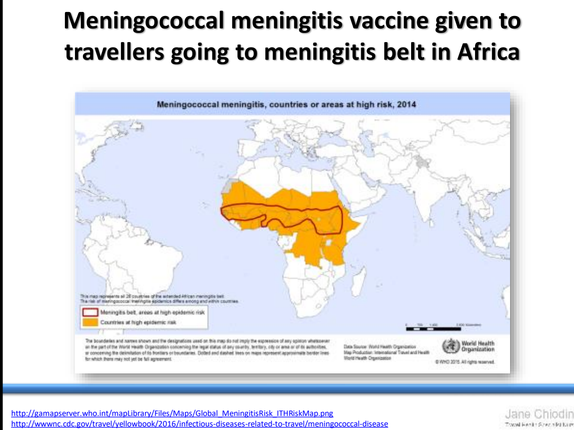

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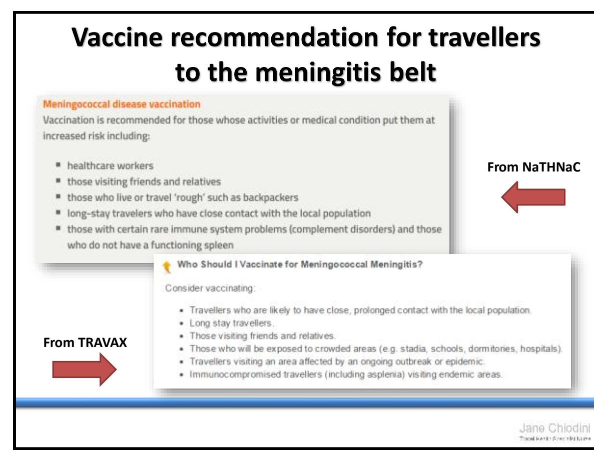

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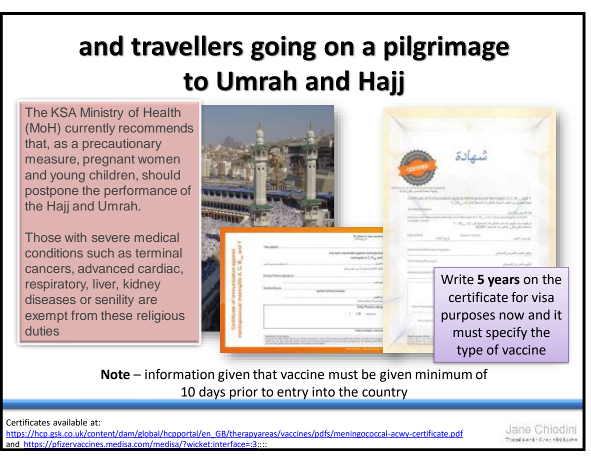

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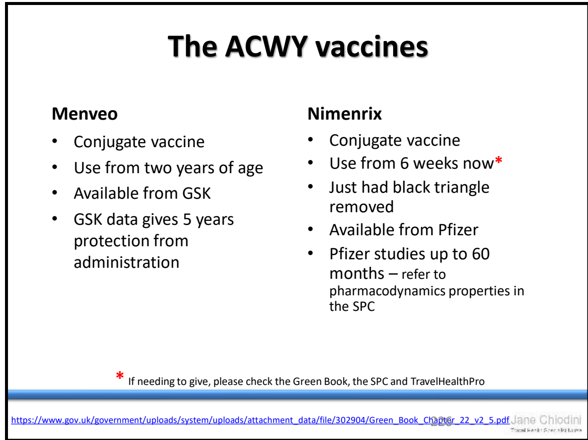

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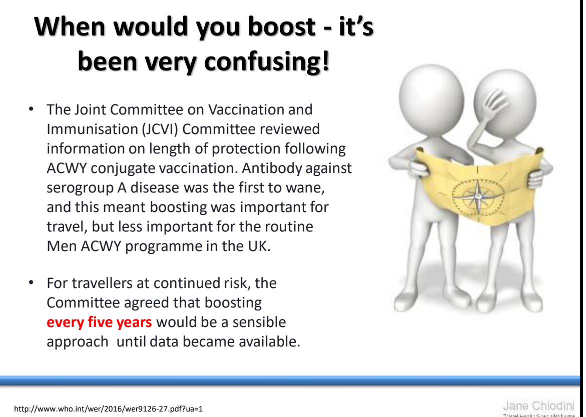

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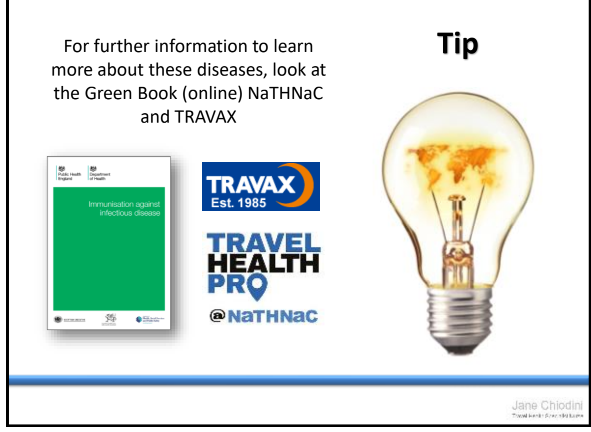

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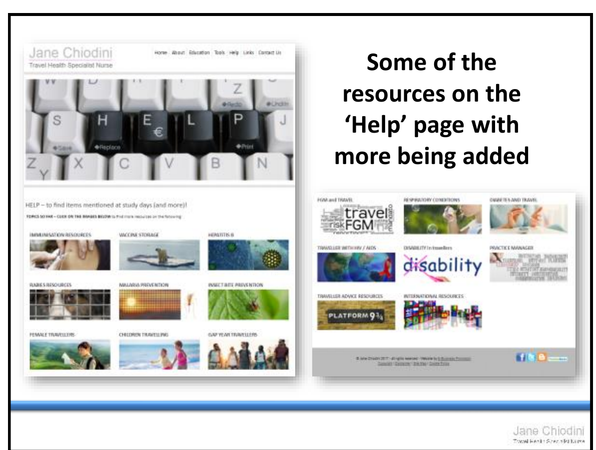

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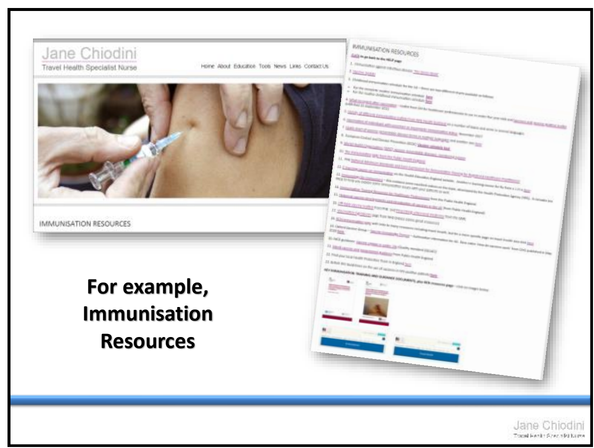

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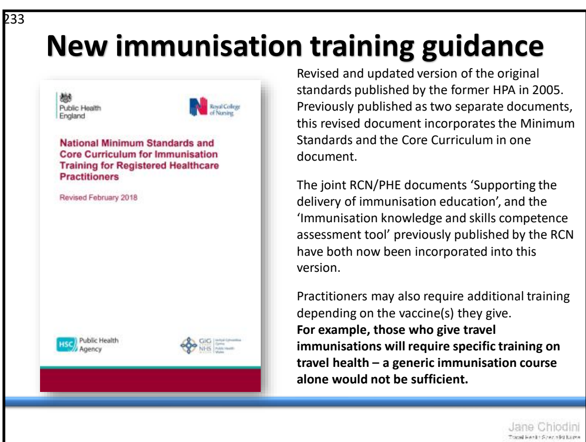

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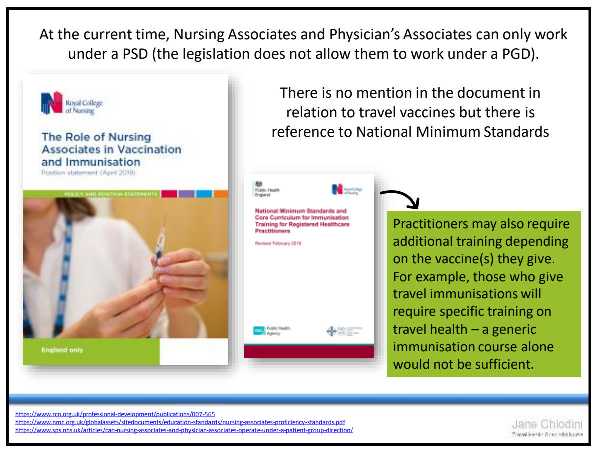

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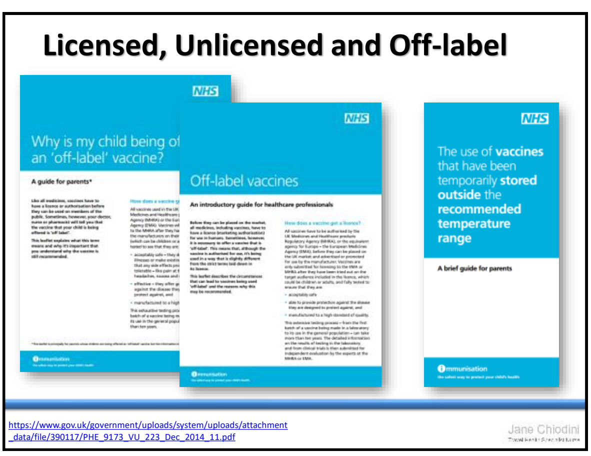

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Immunisation training includes…

- CPR and anaphylaxis
- Consent
- Prescribing
- Administration
- Documentation
- Vaccine storage – protocol
- Finance

Not part of the National Standards, but topics covered briefly on day 2

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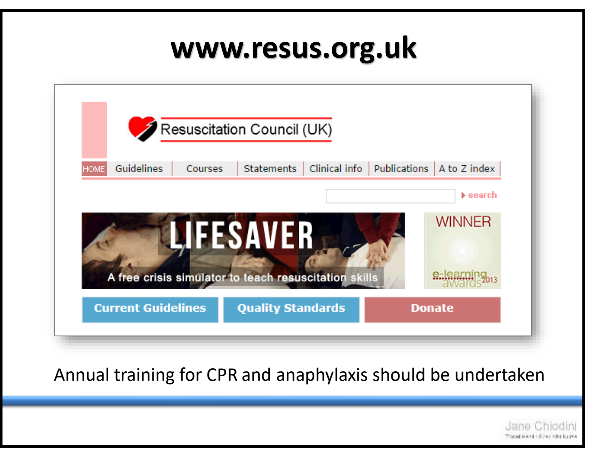

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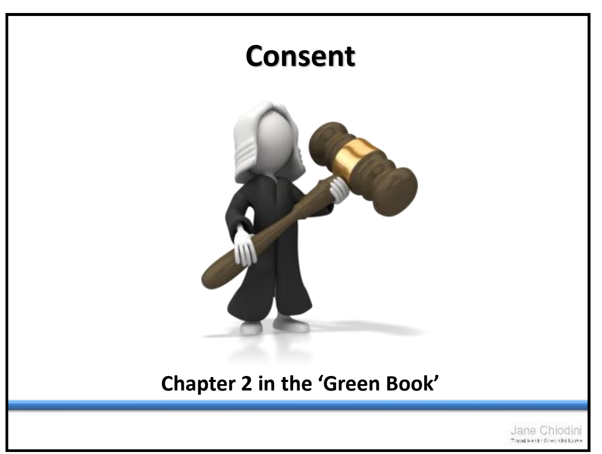

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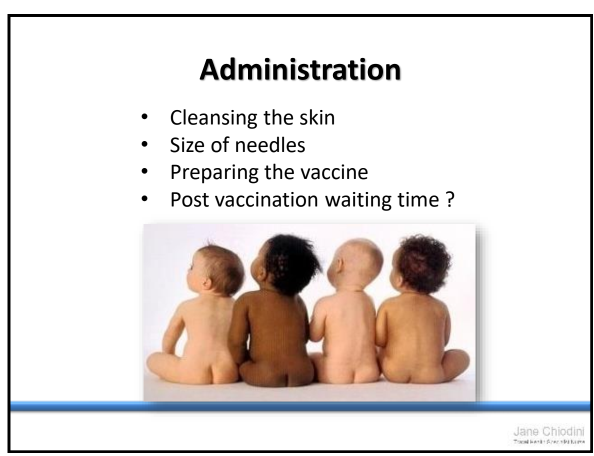

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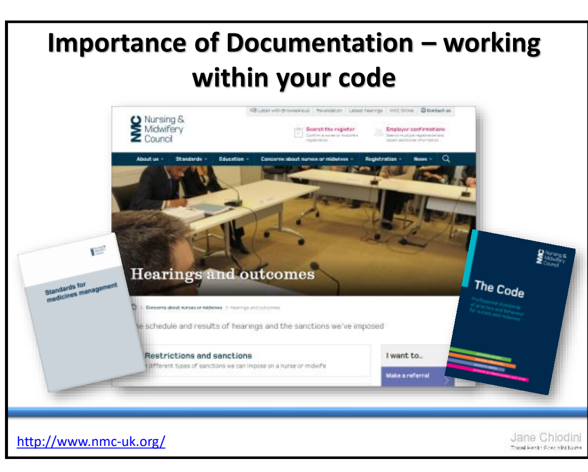

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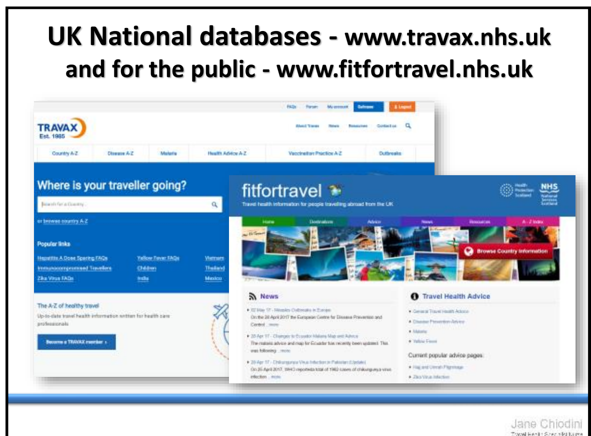

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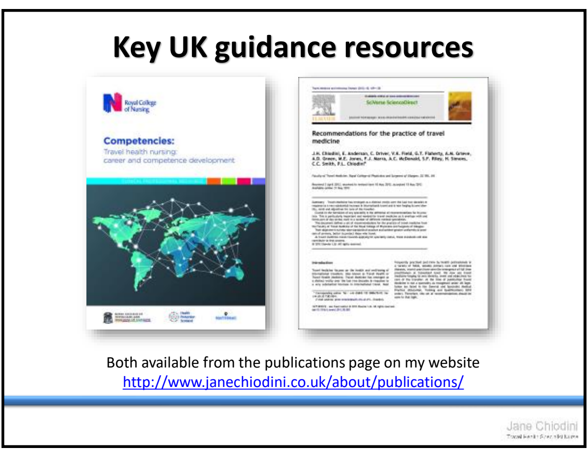

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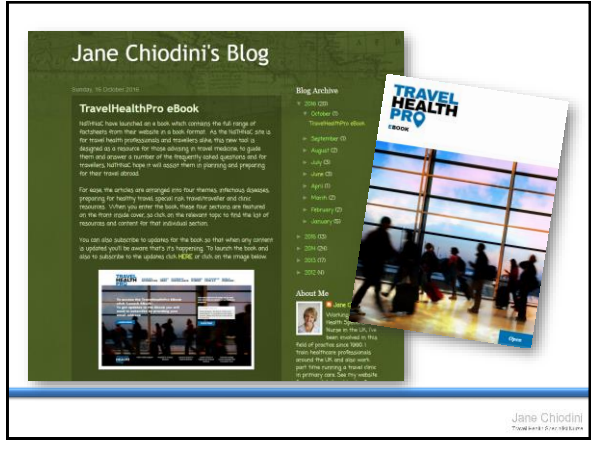

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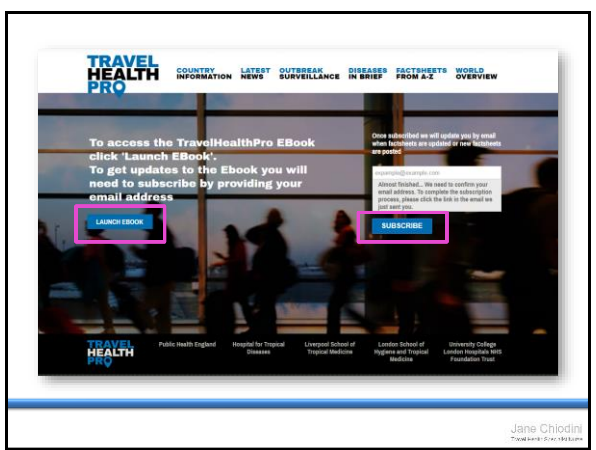

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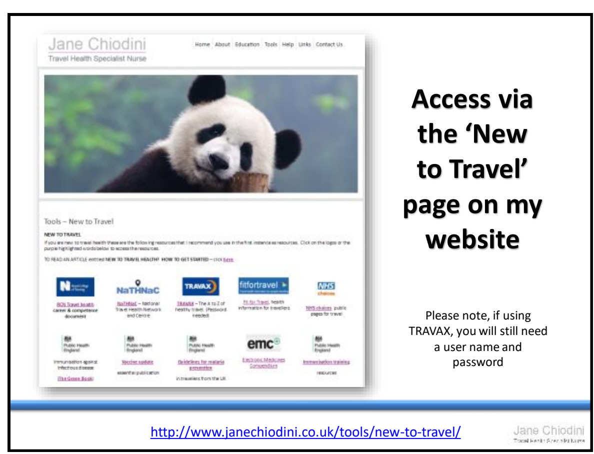

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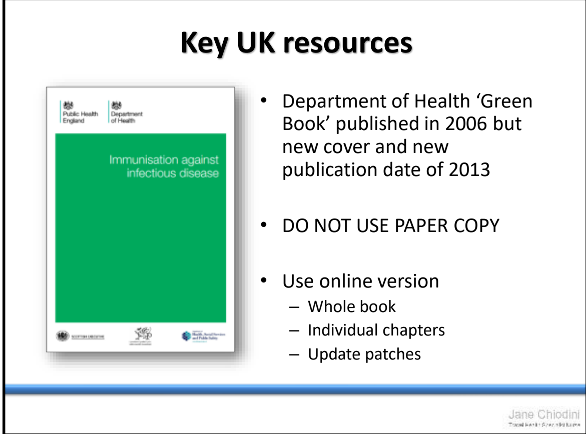

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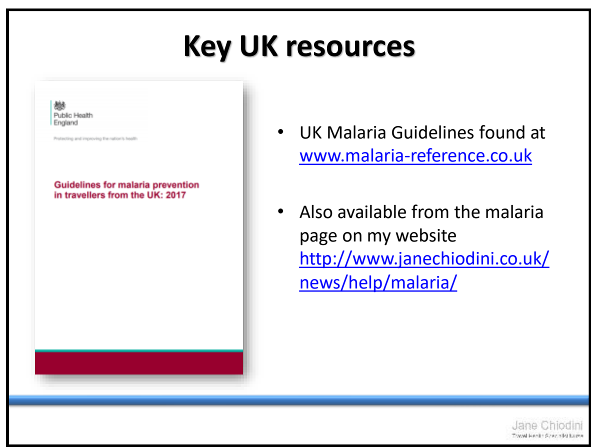

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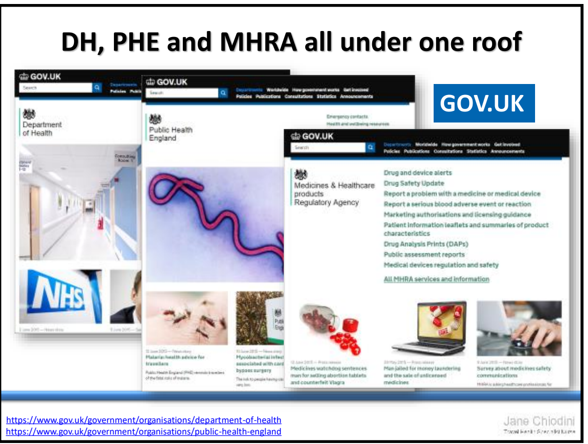

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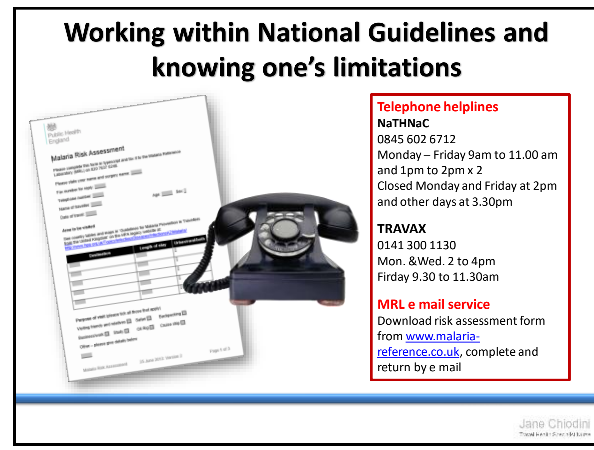

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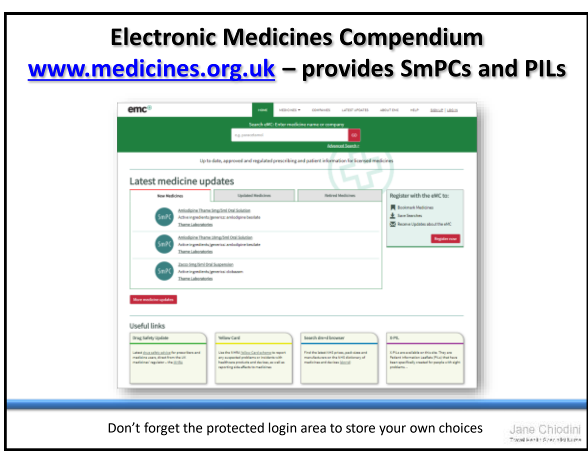

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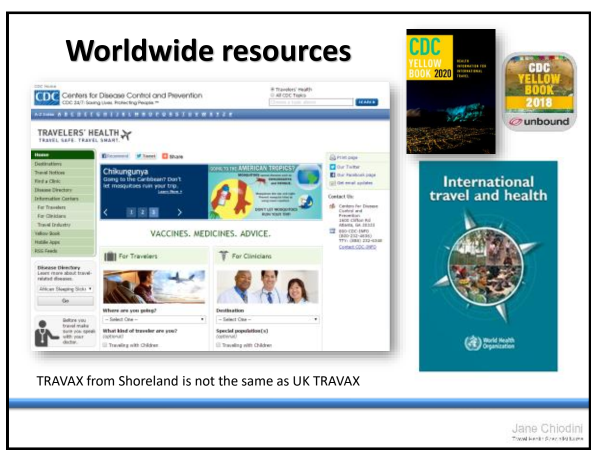

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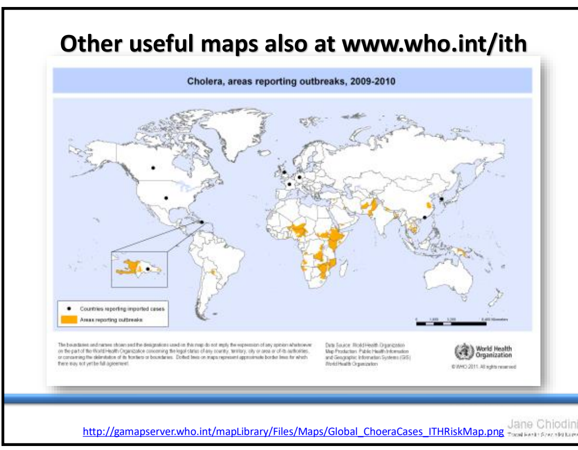

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Finding travel clinics abroad www.istm.org

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Additional websites and resources on my website

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Interim work between the two study days listed on your webpage

- Play the vaccine videos to recap on this aspect
- Look around my website
- Find out what travel PGDs you have at work
- See if you have a vaccine storage protocol at work
- Do the practice case study e learning on your page if you have time left
- Remember you can go into the e learning to reflect on today's presentation if you wish – but only available for a limited time.

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Don't forget to view the tasks suggested if you can for the interim period. See you on Friday 9th August 2019

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