



emporiatics

News, views and reviews
from the Faculty of Travel Medicine



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IBDPassport™: Developing an evidence-based internet travel resource for inflammatory bowel disease

Letter from the Dean of the Faculty of Travel Medicine

Group Captain Andy Green FFTM RCPS(Glasg)

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Editorial

Welcome to the Spring/Summer edition of Emporiatics.

The new Executive Board took up office in October following the annual symposium and AGM. The new Dean sets out his stall on page 3, and on page 4 we give you an insight into the Office Bearers with 'two-minute interviews'. Other Board members will follow suit in subsequent editions. Welcome to all.

Also taking up a new office is Annelies Wilder-Smith, the ISTM President and our In Focus subject on page 9. On page 10 Andy Green, who was working at the centre of the Ebola outbreak, shares his personal, perhaps controversial views about Zika and other insect-borne diseases that are currently capturing the world's attention. As travelling abroad for medical treatment increases, Gerard Flaherty's investigation of stem cell tourism makes fascinating reading on page 6. Nothing quite concentrates the mind like a toothache, and Danielle Colbert has some tips for unlucky travellers with a sudden emergency on page 8. Managing pre-existing medical conditions can be just as tricky, but on page 13 Kay Greveson offers support through her evidence-based resource for inflammatory bowel disease. On page 12 Lorna Boyne provides a wonderful account of her nostalgic trip to India in our Traveller's Tale.

My thanks as always to our contributors.

Sandra Grieve



Andy Green

This is the first opportunity for me to scribble a note in the form of a 'Dean's Letter' to the Faculty since the election of new Office Bearers in October 2015. As such it's probably the right time for me to introduce myself briefly to those of you who don't know me, and - as others have already pointed out - explain that my style is somewhat different to that of previous Deans.

My name is Andy. Which is not intended to sound like an introduction to Travel Medicine Anonymous, but to stop people calling me 'Andrew'. That name is only used by my mother, and by senior military officers when I'm in trouble.

I trained as a doctor at St Georges Hospital in London, then joined the Royal Air Force. I accredited as a Consultant Microbiologist and Consultant in Communicable Disease Control, and have spent my professional career running laboratories and investigating disease outbreaks around the world.

Travel medicine was something I did from the start, initially running yellow fever immunisation clinics and later becoming a founder member of the International Society of Travel Medicine (ISTM) and the British Global and Travel Health Association (BGTHA). This also included teaching and tutoring on the Diploma in Travel Medicine Course since 1997.

More recently, I've been involved extensively in operational deployments to Iraq and Afghanistan, and was at the centre of the UK Ebola response. The latter included the training and supervision of the deployed military Ebola Treatment Facility in Sierra Leone, and serving as clinical lead for aeromedical evacuation of known and suspected Ebola cases.

Andy Green

I've been an elected member of the Faculty Executive Board since 2010, and Vice Dean since 2013. I'm also a member of various national and international committees, including the UK Advisory Committee on Malaria Prevention.

So what?

Being someone who operates outside of the conventional travel medicine community (if there is such a thing) allows me to express opinions and make observations that are sometimes difficult for others to say. And far from being constrained in my views as a result of wearing a uniform, I think this gives me considerable freedom to think - and speak - laterally.

One of the things I've been keen to do is reduce the importance of the Dean as an individual and, instead, devolve responsibilities to the very smart people who have been elected to the Faculty Executive Board.

So while there may be a 'Dean's Letter' in future editions of Emporiatics, these are more likely to reflect consensus views of my colleagues as opposed to my own opinions.

Well maybe. If this all sounds like the description of a Puppet Leader, it remains to be seen whether you will get a Pinocchio (no strings attached) or a Sooty. Ebola cases.

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Bulletin Board

Whither the wherewithal?

FTM Triennial Scholarship

This one-year research fellowship for TM practitioners is a £2,000 grant, awarded every three years, to support a small travel medicine-related project, ideally conducted overseas. The successful applicant presents a report at the Triennial Conference.
<http://rcp.sg/FTMTriennial>

HERE and now!

HERE is a free offline mapping service designed to get people around on foot, public transport or by car in over 100 countries. No internet required for voice-guided, turn-by-turn navigation. Just save maps to your phone and off you go. Start at: <https://pages.here.com/app/?L=1>



Mental health while travelling abroad

Mental health cases involving British nationals has increased by 50 percent in the past five years. See FCO advice at: www.gov.uk/government/publications/mental-health

How-to video for ICVP certificate

Let two senior nurses guide you through the sometimes-tricky task of completing the International Certificate of Vaccination or Prophylaxis (ICVP). It's on YouTube, thanks to NaTHNaC (National Travel Health Network and Centre): <http://travelhealthpro.org.uk/nathnac-yellow-fever-certificate-instructions-2016/>



FGM reporting now mandatory

UK healthcare professionals must report to the police any case of female genital mutilation they come across in girls under 18. See FGM: mandatory reporting in healthcare at www.gov.uk

ISTM Journal goes digital

The first issue in 2016 went up online immediately following publication with members using their ISTM account details to log in. Oxford University Press, the new publisher, has also made past issues and current articles available through the OUP portal: www.istm.org.

Enter Emma Thompson, TB Ambassador!

With 6,520 tuberculosis cases notified in England in 2014 the rate is 12/100,000. The incidence in the non-UK born population was 15 times higher than in the UK-born population. TB is more prevalent in London than in any other capital in the developed world, and in some areas as high as in Sub-Saharan Africa. To raise awareness London Mayor Boris Johnson appointed the Academy Award winning actress to a new role. See a great little video at: www.ucl.ac.uk/tb/news-publication/emma-thompson-appointed-london-tb-ambassador



Travel trends

British travellers are keen to explore new destinations and cruising is increasingly popular with the older generation. The Association of British Travel Agents and Tour Operators (ABTA) in collaboration with the FCO have published a report highlighting key trends in travel.
<http://abta.com/resource-zone/publication/abta-travel-trends-report-2015>

Vaccination OK for HIV-positive adults

Improved prognoses mean that HIV-positive adults are more likely to engage in travel that risks exposure to infection. If evidence indicates vaccination is safe and immunogenic, these otherwise healthy individuals should have protection. See British HIV Association guidelines at: www.bhiva.org/vaccination-guidelines.aspx

Dengue Report updated 2015

Over half of the 347 dengue cases reported in England, Wales and Northern Ireland in 2014 were contracted in Southeast Asia. The remainder were primarily from East Africa, the Americas and the Caribbean. Public Health England report at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/479294/Dengue_fever_2014_FINAL_17_Nov_2015.pdf



2 Minute Interview

The Emporiatics 2-Minute Interview with: Dean Group Captain Andy Green FFTM RCPS(Glasg), Vice-Dean Lorna Boyne FFTM RCPS(Glasg) and Secretary Margaret Umeed FFTM RCPS(Glasg)

All of our Board members have distinguished academic and professional credentials, but what are they really like? We decided to ask our new Office Bearers a few questions ...

Q: What got you started in travel medicine?

Andy Green (AG): As a junior pathologist in the RAF, immunising military and civilian personnel, it became obvious that most people had no idea about health issues related to travel. Thus my simple 'jab parades' turned into what we would now recognise as travel medicine consultations.

Lorna Boyne (LB):

A chance meeting with Fiona Genasi as she and Eric Walker were expanding travel medicine services from the then Communicable Diseases Scotland Unit. I had no travel health experience, but in those days, no-one did!

Margaret Umeed (MU):

I too was inspired by a certain Eric Walker. When I returned from working in Pakistan, travel medicine was my way of continuing in infectious diseases/tropical medicine.

Q: The last music you listened to?

AG: Slipknot
LB: Van Morrison duets and First Aid Kit.
MU: Queen—that's Freddie Mercury, not QE2!

Q: What is your worst (medical) travel incident?

AG: A medical administrator got a last-minute deal on a holiday to the Gambia and took travel health advice in the bar from the most junior doctor in the hospital. No mention of malaria. On his return he presented to his GP with general malaise, and was treated for gastroenteritis. A day later he died of severe falciparum malaria.
LB: I ate mussels prior to an exceptionally rough Channel crossing – I didn't know then that I am allergic to mussels. An indelible memory.

MU: We nearly lost two travellers from the same family who visited relatives in Cote D'Ivoire without taking malaria chemoprophylaxis, despite being advised several times. Their previous visit ended with a horrific road accident. Maybe they shouldn't travel again!

Q: I detest ...

AG: ... arrogance, bigots and people that refuse to listen to advice.
LB: ...mussels!
MU: ... cyclists who ride on the pavement and go through red lights.

Q: Your most grateful traveller/patient?

AG: A soldier was aeromedically evacuated back from Afghanistan with extensive polytrauma. There was no prospect of recovery, but I will never forget his mother –having the chance to say goodbye was beyond words.
LB: I was once asked to read a PhD paper by a complete stranger on an Indian train. He made sure I read every page, then asked for feedback. I certainly hope he was grateful.
MU: I don't normally see patients for phlebotomy only, but did one morning because the treatment room was closed. She seemed pretty unwell so I had her admitted and she suffered a cardiac arrest that afternoon. She suggested later I'd saved her life! I believe there is no such thing as coincidence.

Q: Who has influenced you most in travel medicine?

AG: I'm a mixture of many influences. A bit like a camel ('the horse designed by a committee').

LB: Eric Walker—a visionary who has achieved so much.

MU: The folk who are not PC.

Q: Dog or cat?

AG: Birds.
LB: Cats, but I recently moved to St Andrews and I'm thinking along the dog line ...
MU: Two children and a husband are more than enough!

Q: I'm happiest

AG: ...riding one of my bicycles. I have nine.
LB: ...playing links golf.
MU: ...having dolphins swim beside my dinghy in the Moray Firth.

Q: That guilty pleasure?

AG: My 'fat bike' with its electric motor so I pedal like Schwarzenegger while barely puffing.
LB: DWW (dry white wine).
MU: Chocolate.

Q: The best place?

AG: Overseas, Ascension Island in the mid-Atlantic—a thousand miles from land in any direction. My current mission is to explore as many places as possible in my own country.
LB: Shieldaig in Wester Ross is outstandingly beautiful with great wildlife. Anywhere in India makes me happy and optimistic.
MU: A croft overlooking the Minch, Isle of Lewis—you might see whales from the living room window!

Meet the 2015-16 Faculty of Travel Medicine Executive Board

Office Bearers

Dean – Group Captain Andy Green
Vice-Dean – Lorna Boyne
Secretary – Margaret Umeed

Ordinary Members

Sundeep Dhillon
Carolyn Driver
Katy Geary
Sharon Graham

Associate Members

Dawn Alldridge
Jennifer Anderson

Co-opted Members

Overseas Member - Pål Voltersvik
Hon Clin Reg (MFTM exam) - Angus Menzies
Hon Clin Reg (Dip Trav Med) – Carole Tracey
Director Education Board – Jane Chiodini
Lay representative – Alan MacDermid

The emergence of stem cell tourism: Opportunities and risks

Desperate people seek desperate remedies, and many seriously-ill people take enormous risks when travelling in search of a cure. Gerard Flaherty FFTM RCPS(Glasg) shines the light of research onto some rather shady practitioners and calls for travel medicine to help protect a vulnerable patient group.

Travel health clinicians will already be familiar with medical tourism, whereby people travel to another country to obtain medical treatment, often because the desired treatment is not available in their country of origin. There may be up to 750,000 medical tourists who travel annually for this purpose. Much attention is now being focused on stem cell tourism. Stem cell technologies offer hope for a new era of regenerative medicine which could see previously incurable diseases, such as motor neurone disease, being effectively treated.

Haematopoietic (bone marrow-derived) stem cells are widely established as therapeutic agents in the treatment of diseases of the blood and immune system, including leukaemias. There are currently over 2,000 stem cell trials being conducted around the world and the scientific community awaits the outcome of clinical trials demonstrating the efficacy and safety of this novel therapy for an expanded range of conditions.

In spite of the lack of clinical outcome data, we have witnessed a high demand for stem cell therapy, with many patients and their families searching the internet to identify international clinics which provide incompletely investigated stem cell therapies in an unregulated environment. The public may be unaware that the field of stem cell medicine is much less advanced than they are led to believe by such clinics. The literature contains case reports which underscore the potential risks of receiving untested stem cell therapies, including that of a donor-derived brain tumour occurring in a patient with ataxia telangiectasia who underwent neural stem cell transplantation.



Gerard Flaherty, Senior Lecturer in Clinical medicine and medical education, NUI, Galway, Ireland

“Stem cell tourists may bypass the recommended travel health consultation in an effort to conceal their intentions.”

Apart from the potential complications of the stem cell therapy itself, stem cell tourists may expose themselves to predictable risks associated with travel to countries which are endemic for tropical infectious diseases, including those transmitted via food and water or insect bites. There is also a much higher risk of healthcare-associated infections and acquisition of multi-drug resistant bacterial strains. Stem cell tourists may bypass the recommended travel health consultation in an effort to conceal their intentions to receive unlicensed regenerative therapies overseas.

The facts behind the advertising

My colleagues and I at the National University of Ireland, Galway—which hosts the Regenerative Medicine Institute and national cell and gene therapy manufacturing facility—conducted a web-based analysis of stem cell clinics advertising their services online. The article, which was published in *Travel Medicine and Infectious Disease* in 2014,¹ described a wide geographic distribution of stem cell clinics in 21 countries across five continents.

The USA had the highest clinic density, some of which used clinics located across the Mexican border to administer unlicensed therapies. Other popular stem cell tourism destinations included China, India and Thailand. Overall, more than half the clinics studied were based in developing countries. Remarkably, none of the clinics which we identified discussed infectious disease risks or other travel health risks. Therapies were often embedded in an attractive medical tourism package, which included flights, accommodation, shopping trips and guided tours. The costs of some of the treatments promoted were as high as \$50,000. The language used to describe the clinic was typically misleading and overly positive, with 80 percent of the doctors involved described as ‘specialists’.

A minority of the websites revealed their patient volume or clinical outcome data. About one in ten clinics reported recognised accreditations relating to their clinical practice. Only three percent of clinics referred to peer-reviewed research to support their therapeutic claims.

A worrying finding was that just over half of the clinics required detailed medical records for their tourist patients, and only two out of five clinics mentioned follow-up patient care. Nearly 400 conditions were listed as indications for stem cell therapy, with multiple sclerosis, ageing, Parkinson’s disease, stroke and spinal cord injury being the top five indications featured.

The most common cell type used was adult, autologous stem cells, mostly sourced from bone marrow and adipose tissue. One in ten stem cell clinics used foetal stem cells. In most cases, stem cells were administered via the intravenous route as a single outpatient procedure lasting one-to-three hours.

The role for travel health advisers

Guidelines governing the translation of laboratory stem cell research into clinical practice are available from the International Society for Stem Cell Research,² but these guidelines do not address travel health concerns such as travel vaccinations, malaria chemoprophylaxis, food and water precautions, and other travel health advice.

“Travel medicine should collaborate ...to develop protocols which would demystify stem cell therapies for the non-specialist.”

There is a need to make the travel medicine community more aware of stem cell tourism and its understandable lure for individuals with often incurable chronic conditions, such as type 1 diabetes mellitus, osteoarthritis, end-stage heart failure and muscular dystrophy. Travel medicine should collaborate with the regenerative medicine field to develop protocols which would demystify stem cell therapies for the non-specialist and enable a balanced discussion in a pre-travel consultation about the risks and benefits of travelling overseas for stem cell therapy.

Regenerative medicine may yet revolutionise the delivery of curative treatment for currently unmet medical needs, but international stem cell tourism requires global regulation to prevent undue harm to vulnerable travellers, who turn to international clinics making exaggerated claims for the effectiveness of their largely-untested therapies.

References

¹Connolly R, O’Brien T and Flaherty G (2014) *Stem cell tourism – a web-based analysis of clinical service available to international travellers, Travel Medicine and Infectious Disease* 2014; 12: 695-701.

²Hyun I, Lindvall O, Ahrlund-Richter L, Cattaneo E, Cavazzana-Calvo M et al. (2008) *New ISSCR guidelines underscore major principles for responsible stem cell research, Cell Stem Cell* 2008; 3(6):607-609.



Professor Timothy O'Brien, Director of the Regenerative Medicine Institute in Ireland

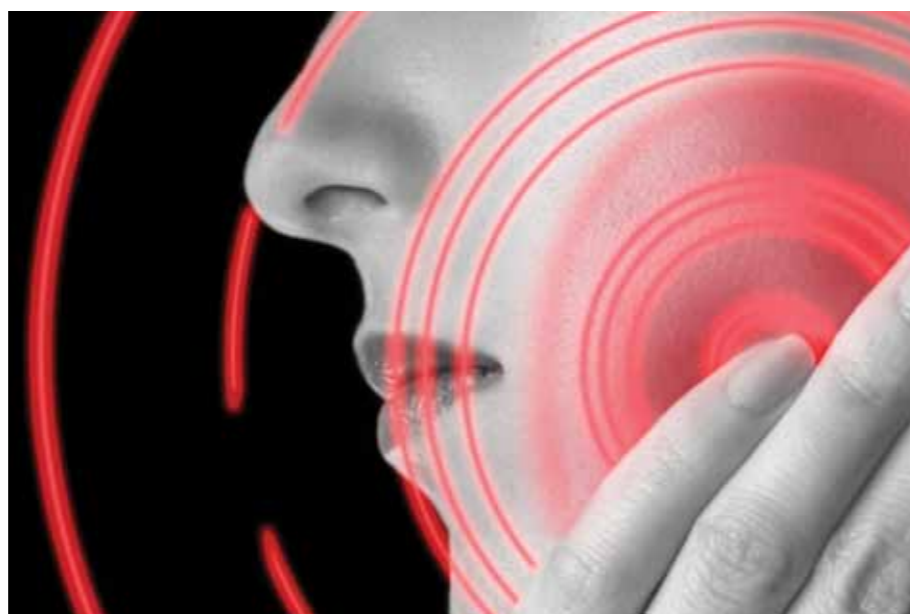
There you are on the Inca trail, gazing at flamingos on Lake Nakuru or trekking in Nepal. Suddenly you get a throbbing toothache or lose a filling. You may be a doctor, nurse or pharmacist, but you're not a dentist - and there's not one of those within a hundred miles. Dr Danielle Colbert has tips that should be part of every pre-travel consultation.

When calling the dentist simply isn't an option ...

If the pulp of a tooth is exposed by fracture or filling loss, it can become very painful and, if untreated, develop into a full-blown dental abscess.

Lucky you for remembering to pack that dental repair kit! These simple kits contain a soft, putty-like paste that you can place painlessly into any exposed cavity. Use it immediately, biting on the paste-filled tooth before it fully sets and removing any excess paste so that the bite becomes comfortable. A very quick fix indeed.

But suppose, like most trekkers, you've come away without a dental kit and no pharmacy in the vicinity has one either. Time to improvise: you've just got to plug it! One expedient is to make do by filling the cavity with something inert, such as a piece of 'pre-chewed' chewing gum, a lump of soft rubber, a few wisps of cotton wool dipped in clove oil or PTFE tape - all cut to size and wedged in place. The challenge then becomes how to prevent swallowing it or, worse, choking on it. I have heard of some extremely inventive folk using Sellotape and glue—necessity can make innovators of us all!



Is that my tooth I see before my eyes?

Anvulsed teeth or teeth that have been knocked completely out of the mouth can often have the best prognosis. This is usually a sports injury or occurs during a theft or nightclub incident. The sad traveller who has this happen to him (and it usually is a 'him') seldom knows what to do, but you do. Find that tooth, clean that tooth (with your own saliva, or with clean running water or milk) and put that tooth straight back into the socket or hole left by its absence! He (or she) must hold it there in the correct position for as long as possible and then avoid eating or putting pressure on it for at least two weeks or until it no longer is painful to do so.

The torn periodontal ligaments attached to the root of the tooth have the highest chances of repair if this is done within seconds or minutes of the incident. After 30 minutes out of the mouth these ligaments start to die.

A crowning achievement

People are renowned for using all types of proprietary glue to stick back crowns, veneers and fillings. Once again a temporary cement from a dental kit is best. Always be careful to avoid contact between glue and non-target tissue such as skin, mucous membrane or eyes!

Broad spectrum antibiotics are essential in controlling a dental abscess and analgesics are important in controlling dental pain. Toothache can be terrible and any attempts to do something active to ease it will be appreciated. Try clove oil or eucalyptus oil on a cotton bud, placed directly on the affected gum or tooth. If this fails then you may have to resort to granddad's cure: give both the patient and yourself a generous helping of whisky!

Dr Danielle Colbert is an elected board member of the Irish Dental Council, Member of the Irish Faculty of Primary Dental Care and owner of the Fresh Breath Clinic: www.thefreshbreathclinic.ie/



IN FOCUS: Professor Annelies Wilder-Smith

Dr Annelies Wilder-Smith FISTM, the new President of the International Society of Travel Medicine (ISTM), gives us an insight into her busy life. She is currently Professor for Infectious Diseases Research at Lee Kong Chian School of Medicine, Nanyang Technological University in Singapore.



Professor Annelies Wilder-Smith

Was medicine your first career choice?

Always, and I've never had regrets despite the often-gruelling hours.

How did you get interested in travel medicine?

Embarking on a career in medicine was - in my mind - always associated with working overseas in developing countries. My primary love has always been tropical medicine: seeing exotic cases, identifying parasites, diagnosing and treating diseases usually not seen in our home countries, and working in developing ones. And this is what I did. I worked in tropical medicine in Papua New Guinea, Nepal and China, ending up in Singapore.

So travel medicine was the logical extension. Travel medicine to me is tropical medicine in returning travellers. However, it is more than tropical medicine. As my career evolved in Singapore, I became more interested in vaccines, running trials and latterly focusing on dengue vaccines.

The TM experience that clearly started it all occurred a few weeks after I took over the leadership of the Travellers' Health and Vaccination Centre in Singapore. An outbreak of an unusual serogroup of meningococcal disease related to the Hajj unfolded and I was asked to provide evidence-based advice to the Ministry of Health. This led to various research grants, research projects and scientific publications, catapulting me into the academic world of travel medicine.

But the biggest turn was in 2003 when SARS hit Singapore. I was working in the 'SARS hospital' at the time and the outbreak had a major impact on my life - personally and professionally. Emails written to ISTM friends and colleagues give a glimpse of what I thought and felt at the time: "The hospital is empty. My clinic was also shut. We have tents set up to do the screening of the suspected SARS patients in Singapore. All schools were closed. Yesterday they started screening at the airport. By definition, I am not allowed to fly anymore as I have been in contact with SARS patients."

"SARS taught me what far-reaching implications a travel-related disease could have."

SARS created international anxiety because of its novelty, ease of transmission and the speed of its spread through jet travel. SARS and travel were intricately interlinked. Travellers belonged to those primarily affected in the early stages of the outbreak and became vectors of the disease. Finally, travel and tourism themselves became the victims.

SARS arrived suddenly, then— after a global wave of deaths and fear - disappeared. It taught me what far-reaching implications a travel-related disease could have. Indeed, I cannot overemphasize the role that travel medicine needs to play in prevention, detection and mitigation. ISTM is there to bring visibility, expertise and a network of travel medicine specialists to enhance exactly that role. This is how I see my current role in travel medicine.

How many languages do you speak?

I speak English, German, Dutch, some French. I tried to master Chinese, but Chinese is an 'eternal language': it takes eternity to learn it! However, during my second pregnancy while unemployed and looking after our first child, I wrote and published a book called *How to take a medical history in Chinese*.

How do you manage multi-country working?

When you love your work, it's so much easier to have stamina for all the stress that we encounter. I really love my work and thrive on multi-tasking, working on different projects in different countries. Indeed, I travel very often, be it in my current capacity as ISTM President or in my role as scientific coordinator for a large EU-funded dengue research consortium.

So where do you go on holiday?

I have lived in Austral-Asia for over 20 years (Singapore, New Zealand, Papua New Guinea, Nepal and China). During our initial years in Singapore, we explored about every single country in Asia during our holidays. However, in the past five or ten years, we increasingly holiday in Europe, mainly because we want our children to experience it. We own a family chalet in the Swiss mountains and use this as a base for holidays.

What is a typical work day like?

My work focus is increasingly centred around research. I do research on emerging infectious diseases, particularly specialising in dengue. I still run two travel clinics every week, but the majority of my time is spent coordinating research, writing grants and papers, preparing lectures and interacting with my global network of researchers and colleagues. It's so much fun, always stimulating, and every day I encounter something new. I count myself blessed to lead such a fulfilling and interesting life.

And the future for the field of travel medicine?

Allow me to answer this in bullet points:

- strengthening the post-travel expertise
- expanding to migration medicine
- incorporating more public health principles
- adding novel vaccines to the armamentarium of available pre-travel vaccines
- embracing our responsibilities as travel medicine providers in conducting sentinel surveillance, addressing issues of emerging diseases that are facilitated by globalization and interacting with big players such as WHO.

Public health emergencies of international concern in the post-Ebola world



Whether or not the current furor over Zika prove to be a kneejerk reaction, it gives travel medicine practitioners a chance to grab the attention of the travelling public and deliver some much-needed practical advice. Group Captain Andy Green FFFM RCPS(Glasg) offers some insights.

As the Ebola outbreak drew to its close towards the end of 2015, the international community breathed a collective sigh of relief. The world had escaped the threatened global extinction event by a combination of well-directed and proportionate responses, which allowed targeted resources to be directed to maximum effect, first to control and then to stop the outbreak.

The mutual congratulations that followed were tempered slightly by knowing that late relapses or recurrent infection might happen, which mandated extended surveillance in

those countries primarily affected for at least 90 days following the last recorded case—and perhaps much longer. In addition, many nations announced plans for enhanced detection and surveillance programmes for novel infectious diseases, coupled with aspirations to establish international response teams for future outbreaks, although details of organisation and funding have not yet been determined.

A contrarian view of the Ebola outbreak Response, authored by a group of international academics, was critical of the lack of leadership provided by the World Health Organisation (WHO), and made a series of recommendations for immediate actions to prevent any future similar event compromising a fragile global health infrastructure.

The wide-ranging reforms they suggested were considered feasible and achievable by the expert group. Specifically, they addressed those key areas that governments and international bodies had avoided, such as improvements to basic primary health care systems, detection and recognition of novel diseases in resource-

poor regions, multinational intervention teams, rapid and open sharing of information between nations, and — perhaps most importantly — a recognition that objective oversight and governance of any future responses is essential.

Other observers were more overtly critical in their opinions. There was a widely-held view that the WHO was slow to react to the initial reports of Ebola Virus Disease in early 2014, and delayed declaration of a Public Health Emergency of International Concern (PHEIC) until the outbreak was out of control. There was further criticism that the international response was provoked only by perceived threats to nations themselves, and that many of the interventions were targeted at prevention of imported disease rather than outbreak control at source. Indeed, many of the actions by nations were not only inappropriate, but also detrimental to care of individual patients with confirmed or suspected disease.

So how well prepared are we in 2016?

As I write, the predicted appearance of a new emerging and persistent infectious disease has already occurred. On 1 February 2016 the WHO declared a PHEIC in response to the spread of Zika Virus Disease across the Americas. However, there is a question whether this represents a measured and proportionate response to an international health crisis, or is it the action of an international community anxious to be seen to be not delaying intervention on this occasion.

“This provides the opportunity to discuss other — arguably more important — travel health issues. For example: bite prevention measures, early reporting of any illness during or after travel, and improved compliance.”

“Like Ebola, Zika is newsworthy. It has an interesting name—and the potential to disrupt the 2016 Olympic Games”

Why might one ask?

Zika is not a new infection, having first been described in Africa in 1947. It is spread human-human by mosquitos of the *Aedes* genus, including *Ae aegyptii* and *Ae albopictus*. In other words, the vectors are similar to those for yellow fever, dengue and chikungunya. Diagnosis is not easy and relies on the availability of recognised laboratory testing, but it seems likely that the virus has migrated (either in people or mosquitos) across the Pacific Region and arrived in the Americas within the last decade. During 2015 there were an estimated 1.5 million cases in South America (primarily Brazil).

The disease is a typical arbovirus infection clinically with fever, rash and myalgia predominant. What excites interest is the observation of clusters of microcephaly in children born in regions where Zika is now endemic (4,180 cases in Brazil in 2015), although at time of writing only three cases have been shown to have evidence of Zika infection. In contrast, during 2015 there were an estimated 50 million cases of dengue worldwide, 15 million of them in Brazil. Worldwide malaria deaths had fallen to an estimated 500,000, which was considered a success. Chikungunya had a similar epidemiological pattern to Zika, starting in Africa in the 1950s and then becoming endemic worldwide. Its importance in 2015 was demonstrated by local transmission within Europe as far north as France, with *Ae albopictus* as the vector.

Yet, unlike Zika Virus, none of these diseases has been declared a PHEIC despite causing a greater burden of disease and death.

Implications for the travel medicine practitioner

Like Ebola, Zika is newsworthy. It has an interesting name—and the potential to disrupt the 2016 Olympic Games. The advice from Public Health England, based on that of the WHO, is very risk averse. For a disease that is mosquito-borne and causes millions of cases per annum, there has been media focus on the theoretical sexual transmission of disease from returning (male) travellers — despite there being only anecdotal case reports. In addition, disinfection of aircraft arriving from the Americas has been initiated, even though the vector is already widely present in Europe. The risk of disease transmission by an infective mosquito to passengers during flight is close to zero.

However, this infection should be regarded as an opportunity for the travel medicine community to promote its importance to the travelling public. The UK Government advice and that of the WHO might not necessarily be logical or proportionate, but it is unlikely to do harm. What it will do is raise the profile of diseases associated with travel, and most likely mean that people attend for pre- and post-travel advice who may not have done so otherwise.

This provides the opportunity to discuss other — arguably more important — travel health issues. For example: bite prevention measures, early reporting of any illness during or after travel, and improved compliance with malaria chemoprophylaxis when indicated.

The post-Ebola world is less tolerant of risk from diseases associated with travel. It is up to travel medicine practitioners to ensure that the travelling population knows who to consult for advice on reducing that risk.

The views expressed in this article are personal observations of the author, and do not reflect the position of the Faculty of Travel Medicine or of the Defence Medical Services.

Please contact the Editor for references.



Zika Resources UK

Search at www.gov.uk for 'Zika virus – epidemiological and guidance update' for a compendium of links to the latest news and information.

'Zika virus infection: guidance for primary care' is particularly helpful. Health professionals are asked to be vigilant and consider ZIKV in patients with fever who are returning from the Americas, especially those with a history of travel to areas of ZIKV transmission.

Advice for pregnant women, those planning pregnancy and their partners travelling to Zika affected areas. <http://travelhealthpro.org.uk/two-new-zika-resources-available/>

Blood donor guidance

Current guidance in all four countries of the UK imposes a 28-day blood donation deferral, so long as no symptoms of Zika are present, on anyone who has travelled to a ZIKV-endemic area. Check individual services for latest updates: England & North Wales (www.blood.co.uk), Scotland (www.scotblood.co.uk), Wales (www.welsh-blood.org.uk) and Northern Ireland (www.nibts.org/index.html).

NaTHNaC

Travel Health Pro has quick links to Zika information and a filter for individual information at: <http://travelhealthpro.org.uk/zika-virus-quick-links/>

TRAVAX

- www.travax.nhs.uk/news.aspx (health professionals login required)
- www.fitfortravel.nhs.uk/advice/disease-prevention-advice/zika-virus-infection.aspx (open access)

TRAVELLER'S TALE

India: Timeless, but never the same

Lorna Boyne FFTM RCPS(Glasg) celebrated a milestone birthday by returning to India after 15 years. Previous visits had her organising educational outings for Travel Medicine Diploma students and working in clinical learning sessions with the Christian Medical College in Vellore. She had seen rabies vaccine produced and snake anti-venom collected, and took a memorable trip to a sewage plant, but also had magical memories of unspoiled beaches in Goa, small boys on large elephants, overnight train trips and Kerala waterways by boat. So many memories ... but what would the reality be today?

A few years ago I became hooked on a television series about Indian train travel and, after seeing the 'Toy Train' journey from Kalka to Shimla in the Himalayan foothills, I decided this was something my husband John and I had to experience. We eventually based our entire trip around train travel – and anyone who has travelled by train in India will know that it's great fun and a real experience.

Flying into the ultra-modern, spotless airport at Delhi I immediately realised we were going to see great changes. After delving into Indian history in that great city and visiting Ghandi's grave, our long-anticipated Kalka-to-Shimla trip did not disappoint. This UNSECO world heritage journey is on a narrow gauge train over 97 km, taking seven hours to complete as it rises to almost 7,000 feet. The train winds up from the Himalayan Sivalik foothills at Kalka to Summerhill and Shimla, known as the 'Summer Capital' of India where the British would retreat from the heat

Shimla feels different from other parts of India I'd visited and the British influence is much more evident here, having come under the British Raj in 1817.

Travelling to Agra in Uttar Pradesh, I was keen to see the Taj Mahal, but wondered if I would be disappointed. It was built by Mughal emperor Shah Jahan to house the tomb of Mumtaz Mahal, his favourite wife, who died giving birth to their 14th child. The Taj Mahal is often described as heartbroken Jahan's monument to love. Made entirely from white marble, at sundown it changes to light pink. We watched the sunset over the Yumana river and it was magnificent, magical and very romantic.

Our final destination was Jaipur in Rajasthan, often called the 'Pink City' because many buildings are made of pink and red sandstone. Others were actually painted pink to welcome Queen Victoria and Edward VII, and remain



Lorna at the Taj Mahal

Shimla feels different from other parts of India I'd visited and the British influence is much more evident here, having come under the British Raj in 1817.

pink to this day. We particularly enjoyed the Amer fort and Hawa Mahal (Palace of Winds), constructed as a screen to enable the women of the royal household to watch street activities unseen. Jaipur's large market is renowned for traditional block printed textiles.

So many changes in 15 years

Road traffic had increased significantly and traffic jams are common with many more cars than rickshaws. On previous visits I'd be asking to take photos of people we met. Now we were constantly asked to pose for photos and to have 'selfies' taken with us. The dress code for tourists is less modest, sometimes alarmingly so.

What I cannot capture here is the way that just being in India affects you. The sensory stimulation is difficult to describe: noises and smells, tastes of the wonderful food and being drawn along by the crowd in packed spaces.

The willingness of everyday Indian people to engage with the slightest encouragement leaves a lasting impression.

We can't wait to go back: there is so much more to experience and next time we won't leave it so long.



Hawa Mahal, the Palace of Winds

IBDPassport™:

Developing an evidence-based internet travel resource for inflammatory bowel disease

Kay Greveson reports

Inflammatory bowel disease (IBD) when combined with foreign travel is associated with an increased risk of travel-related morbidity caused through exacerbations of IBD, acquisition of infectious diseases endemic to the destination and availability of healthcare and medicines while abroad.

Patients receiving immunosuppressive medication have an increased susceptibility to these infections in addition to an attenuated immune response to vaccinations. Detailed pre-travel consultations and vaccinations are advised prior to departure to ensure travellers are armed with the appropriate education and resources to stay healthy during their journey. Despite guidelines specifying appropriate vaccination strategies for IBD patients, knowledge and provision of this information have been found to be poor, particularly vaccination for those on immunosuppressive medication.

Research conducted at the Royal Free Hospital revealed a paucity of information for IBD patients wishing to travel and also found that individuals with IBD do not always seek adequate pre-travel medical advice—including obtaining travel insurance or understanding

the need to avoid live vaccinations if immunosuppressed. The study supported the call for further research of travel behaviour in IBD and a need for greater IBD-specific travel education and awareness for both patients and healthcare professionals.

IBDPassport™

The findings from this research, along with evident gaps in the literature, led me to develop the IBDPassport™ (www.ibdpassport.com), an online travel resource for inflammatory bowel disease. The website was developed for both IBD patients and healthcare professionals as a non-profit, IBD-specific travel resource. The primary aim was developing patient-centred information to support living with this condition and to improve education and pre-travel preparation by providing evidence-based information on all aspects of travel and IBD.

The website draws together evidence-based information from national and international IBD guidelines, patient organisations and government literature in one resource and includes practical information on issues such as obtaining healthcare overseas, managing travellers' diarrhoea, travel following surgery and details regarding travel insurance and vaccination advice specific to immune-compromised patients.

The IBD Network page contains an interactive map of country-specific vaccination advice and a 'search and refer' directory of IBD centres to enable IBD healthcare professionals to refer to other IBD centres globally. Populating the directory of IBD centres depends on those centres registering with the site, although I will enter some IBD centres manually to ensure the information is comprehensive and helpful to users.

New features include my Wellness Journal App to enable patients to carry their healthcare documents securely in their mobile device. A section for healthcare professionals contains posters and patient leaflets to display in clinics, along with a summary of all the published IBD and travel research, and popular guidelines. The website also has Twitter (@IBDPassport) and a Facebook page where travel and IBD-related information is regularly shared.

All healthcare professionals are encouraged to register with the site and make patients aware in order to reduce travel-related illness through improved awareness and education.

Kay Greveson is Inflammatory Bowel Disease Nurse Specialist at the Centre for Gastroenterology, Royal Free Hospital NHS Foundation Trust in London.

Please contact the Editor for references.

RESOURCES

On the Faculty of Travel Medicine education front

Jane Chiodini, Director of Education and Professional Development, reports that the new Faculty Education, Training and Professional Development Board is busily planning educational meetings up to the end of the 2017 academic year – watch for news in the College's Education Prospectus this summer. Meanwhile a longer term strategic plan for education is being developed with the hope that some exciting new educational materials will be launched in June at NECTM6 on the Faculty exhibition stand.

More on Jane's vision for the future in the winter edition of College News. rcp.sg/CNAW2015

Malaria Guidelines UK 2015

Chiodini PL, Patel D, Whitty CJM and Laloo DG (2015) Guidelines for malaria prevention in travellers from the United Kingdom, London: Public Health England; www.gov.uk/government/uploads/system/uploads/attachment_data/file/461295/2015.09.16_ACMP_guidelines_FINAL.pdf

Migrant Health Guide

In light of current events, this 2012 resource is being updated. Progress in the next edition.

Meantime: Advice and guidance for healthcare practitioners on the health needs of migrant patients. Non-communicable health concerns: migrant health guide:

www.gov.uk/government/collections/non-communicable-health-concerns-migrant-health-guide

Immunisation: Migrant health guide: www.gov.uk/guidance/immunisation-migrant-health-guide

WHO Publications

- World Malaria Report 2015. Millennium Development Goals targets were met and the number of cases fell, however, 3.2 billion people remain at risk with an estimated 214 million new malaria cases and 438 000 deaths in 2015. www.who.int/malaria/publications/world-malaria-report-2015/en/
- World Sanitation Report – MDG Assessment 2015 for Sustainable Development Goals. www.wssinfo.org/fileadmin/user_upload/resources/JMP-Update-report-2015_English.pdf
- Global TB Report 2015 From 2016, the goal is to implement the End TB Strategy. www.who.int/tb/publications/global_report/en/

RESOURCES

Conferences

NECTM6

6th Northern European Conference on Travel Medicine

1-4 June 2016

Queen Elizabeth II Conference Centre, London

<http://nectm.com/>

RCN/Faculty of Public Health Conference

Public health in a cold climate: Melting hearts & minds with evidence

14-15 June 2016

Brighton Centre

ICTMM 2016

The XIX International Congress for Tropical Medicine and Malaria

18-22 September 2016

Brisbane Convention & Exhibition Centre

Brisbane, Australia

<http://tropicalmedicine2016.com/>

South African Society of Travel Medicine Biennial Congress

ISTM 7th Regional Congress

Travel health Africa – the boiling point?

28 September-1 October 2016

Boardwalk Convention Centre

Port Elizabeth

www.sastm.org.za/Events/Details/15

Faculty of Travel Medicine Annual Symposium

10th anniversary event

6 October 2016

Royal College of Physicians and Surgeons of Glasgow

Glasgow

<http://rcp.sg/FTM10>

CISTM15

14-18 May 2017

Barcelona, Spain

www.istm.org

Northern European Conference on Travel Medicine (NECTM6) London 1-4 June 2016

A personal invitation from Dr Dipti Patel, Chair of NECTM6 Scientific Committee

NECTM6 is fast approaching, with the conference programme almost finalised. It has been developed to update, stimulate, challenge and encourage networking. We have renowned speakers from all over the world. The mix of keynote speeches, scientific symposia, workshops, free communications and new 'knowledge bites' sessions is designed to cater for all levels of experience. We hope the latter in particular will appeal to those new to the speciality.

Programme topics, to name a few, include:

- the future of travel and tourism
- antibiotic resistance and the traveller
- Ebola: lessons learned and future directions
- the health of refugees and displaced persons
- one-health from an animal perspective
- the vaccine confidence gap
- globalisation of the healthcare market
- the VFR traveller in the 21st century

Among our many eminent speakers are Professor Robert Steffen, Professor Leo Visser, Professor Pat Schlagenhauf-Lawlor, Professor Annalies Wilder-Smith, Professor Dilys Morgan and Dr Ron Behrens.

Email teamnectm6@in-conference.org.uk to get involved in the NECTM6 Charity Project. Make a donation or sponsor team NECTM6 at: www.justgiving.com/Team-NECTM6.

The ISTM Certificate in Travel Health CTH® takes place on 1 June in London. More at: www.istm.org/certificateofknowledgerc

Registration and everything else to do with this great event at: <http://nectm.com/>

See you in London!



From the Journals

Heywood AE, Forssman BL, Seale H, et al, (2015). General Practitioners' Perception of Risk for Travelers Visiting Friends and Relatives.

Journal of Travel Medicine 2015; 22 (6): 368–374. doi: 10.1111/jtm.12229

Shanks G D (2015) Insights from unusual aspects of the 1918 influenza pandemic.

Travel Medicine and Infectious Disease (2015) 13, 217-222

Noone P, Hamza M, Tang J and Flaherty G. (2015) Standards of yellow fever vaccination and travel medicine practice in the Republic of Ireland:

A questionnaire-based evaluation. Travel Medicine and Infectious Disease 2015, 13 (5) 409-414

<http://dx.doi.org/10.1016/j.tmaid.2015.06.007>

Chen L. (2016) Zika Virus Infection in a Massachusetts Resident After Travel to Costa Rica: A Case Report.

Ann Intern Med. Published online 10 February 2016 doi: 10.7326/L16-0075

<http://annals.org/article.aspx?articleid=2492129>

Flaherty GT, and Choi J. (2016) Review. The 'selfie' phenomenon: reducing the risk of harm while using smartphones during international travel.

Journal of Travel Medicine, 23 (2) 2016, 1–3. doi: 10.1093/jtm/tav026

Oldenburg M, Herzog J, Pu K and Harth V (2016). Mortality of German travellers on passenger vessels.

Journal of Travel Medicine, 2016, 1–5. doi: 10.1093/jtm/tav003

New course for expedition medics

James Moore FFTM RCPS(Glasg) and Jon Dallimore FFTM RCPS(Glasg)



The Diploma in Expedition and Wilderness Medicine is a new course designed and directed by two of the editors of the international bestselling Oxford Handbook of Expedition and Wilderness Medicine, Jon Dallimore and James Moore. The course can be completed over 12 or 24 months. The programme is currently undergoing assessment by Glasgow Caledonian University.

Expedition medicine is a growing sub-specialty spanning a range of disciplines - pre-hospital care, tropical medicine, travel medicine and global health. It gives medical professionals who want to further their skills in expedition or wilderness medicine an opportunity to do so through an academically recognised course, housed in a medical Royal College and free from commercial involvement.

For more information please visit our website: <http://rcp.sg/expedmed>

or contact Lesley Haldane
lesley.haldane@rcpsg.ac.uk
+44 (0)141 221 6072

The course combines online learning packages with four weeklong face-to-face residential modules with practical teaching on location in extreme environments including:

- Infectious disease, travel medicine and global health – Royal College of Physicians and Surgeons of Glasgow
- Tropical and maritime medicine - Devon
- Cold and mountainous - Glenmore Lodge, Aviemore
- Desert and high altitude - Morocco

The course is a mix of practical skills, theory and assessment, delivered by field and subject experts in the most appropriate environments.

It will involve a significant amount of non-medical teaching by trained mountaineers and outdoor instructors as medical skills form only about a third of the actual skills required on an expedition.

Once accreditation of the course is approved, candidates who successfully complete the programme will earn a post-graduate diploma (level 7) - well on the way towards an MSc.

5
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6 October 2016

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