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Editorial

From Nepal to antibiotics

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

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

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

My thanks as always to our contributors.

Sandra Grieve
What's new from WHO

- The WHO/UNICEF Joint Monitoring Programme, established in 1990, has published its findings on the challenges faced by half the world’s population living without safe drinking water and basic sanitation: www.wssinfo.org/ReadMeIn/user_upload/resources/JMP-Update-report-2015_English.pdf
- The Global Advisory Committee on Vaccine Safety met in the summer to examine WHO’s record in monitoring dissemination of vaccine safety information and review data related to the safety of novel vaccines against Ebola virus and dengue.
- Immunisation data published by WHO and UNICEF shows that 129 countries now vaccinate against measles, mumps, and rubella, more than twice as many as in 2000. Central African Republic, Chad, Equatorial Guinea, Nigeria, and Somalia have announced a series of projects, publications and events to celebrate its centenary in 2016 at: www.rcn.org.uk/aboutus/our_history/centenary/projects
- A lot of travel-related illness occurs in Nepal, ranging from altitude illness to gastrointestinal infections. Bearing this in mind, the 11th Asia Pacific Travel Health Conference: www.aphthc2016.com is being held in Kathmandu next March at the historical Fair and Few Hotel. Along with the usual topics, there will be a pre-conference workshop focusing on altitude illness, a certifying examination of the International Society of Travel Medicine and post-conference organised trekks. Along with world-class speakers and plenty of 'opportunity for get together', delegates are invited to see the monuments that survived the earthquake and have fun in this adventure travel destination.

Bulletin Board

Share the spotlight

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

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

The RCN—100 years on

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

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

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New edition of Yellow Book

The latest CDC Health Information for International Travel is now available online at wwwnc.cdc.gov/travel/page/yellowbook-home Print versions can be ordered and a mobile app is coming soon.

From the UK Foreign and Commonwealth Office

- Know Before You Go: the British Embassy produced a handy postcard guide with travel tips for British nationals in Qatar in advance of their summer holidays. General KBYG information is at: www.gov.uk/knowbeforeyougo

Updated UK Malaria Guidelines

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

Nepal earthquake sends aftershocks through the health system

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

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

In remote mountainous districts, health facilities collapsed, leading to loss of physical infrastructure and damage to supplies and medicines. Some 456 health facilities were destroyed and a further 650 were partially damaged, with health care delivery being provided through makeshift tents and camps.

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

Assessing the damage

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

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

Asia Pacific Travel Health Conference

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Find out more about the CIWEC Clinic at: www.youtube.com/watch?v=3BApUrrPjWw

CIWEC Hospital and Travel Medicine Centre, Kathmandu.
Senior travellers: The importance of travel medicine in domestic travel

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

World Heritage-listed Lord Howe Island is less than two hours’ flight from Brisbane or Sydney off the east coast of Australia. Its small size (56 km²), spectacular geography and highly diverse flora and fauna provide unparalleled experiences of natural beauty on the world’s southern-most tropical island. Home to about 350 local residents and 150 itinerant workers, a maximum of 400 tourists are


taken right up to the edge. There are no traffic lights or roundabouts and street lighting is minimal. The 11 km of sealed roads are without footpaths or kerbs, with island foliage often growing over the road.


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

**Methodology**

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

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

**Seniors’ activities and potential health threats**

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

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

**Use of medical facilities**

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

**Pre-trip preparation**

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

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

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

For Tables and References please contact the Editor:
awcg1@btinternet.com

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**Tracks**

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

**Medical facilities**

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

**Remoteness**

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

**Prevention on the island**

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

**General recommendations**

To give high quality pre- and post-travel care, travel health advisers may need to inform themselves about domestic destinations that are popular with older people.

For Tables and References please contact the Editor:
awcg1@btinternet.com
**TRAVELLERS’ DIARRHOEA: It’s time to give up old habits of prescribing antibiotics**

A challenge from Anu Kantele FFMT RCPS(Glas), Tinja Lääveri and Lars Rombo FFMT RCPS(Glas)

**The challenge**

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

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

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

**New UK guidance**

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

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

**Discussion:**

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

When did you first become interested in travel?

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

Did you always want to be a doctor?

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

How did you get into travel medicine?

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

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

What did you do at the BBC?

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

When did you begin to move into more strategic roles?

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

By the time I returned to the FCO, I felt able to make a real difference in strategic areas. Examples of some of the work I do there include looking at the FCO’s approach to malaria prevention in staff and dependants, or the potential health effects of air pollution for staff and dependants places such as Beijing or New Delhi.

The job at NaTHNaC was the next obvious step for me, and I was happy to job share because I didn’t want to give up my work at the FCO. Both positions complement each other.

What is a typical day at NaTHNaC?

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

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

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

**New NaTHNaC website launched**

Check out this user-friendly and valuable resource for health professionals

http://nathnac.net/

**What**

Breath-taking numbers!

In FOCUS:

Dipti Patel FFMT RCPS(Glas)

**When**

You may upset the balance of the microbiota for a long time—up to two years after treatment. By killing members of the intestinal microbiota, the drugs also pave the way for newcomers which include strains resistant to antibiotics. Recently, both TD per se and its treatment with antibiotics have been shown to predispose travellers to contracting resistant intestinal bacteria while travelling. The risk is greater for visitors to countries with poor standards of hygiene and weak or non-existent antimicrobial policy. The risk is exemplified by our recent investigation in which 67% of travellers had TD. ESBL-PE was contracted by 11% of healthy travellers (TD−AB−), 21% of those with TD taking antimicrobials (TD+AB+) and 37% with TD not taking antimicrobials (TD+AB−). The respective figures for the region with highest risk, South Asia, were 25%, 49% and 80%. Breath-taking numbers!

**Where**

It’s time to give up old habits of prescribing antibiotics.

**How**

Numerous studies show antibiotic treatment to be efficacious against TD. This has been proven with several drugs such as fluoroquinolones, macrolides and rifaximin.

**Why**

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**Do**

The risk of contracting a clinical infection by the bacteria has three levels of significance: individual, societal and global. The individual’s risk of contracting a clinical infection by the bacteria may range from mild cystitis to life threatening conditions.

**Can**

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Ebola: A personal journey

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

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

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

Ebola Convalescent Plasma Treatment

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

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

The Ebola CP Study

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

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

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

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

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My role in the Ebola CP Study

I was involved in building relationships, liaising with the blood bank, MH4 and Clinical RM, preparing sites for monitoring visits, auditing case report forms and stored specimens in the Blood Bank, compiling lists of donors, helping to plan the next phase of the trial, liaising with representatives from Ebola survivor groups, and providing GCP training and input into updating the protocol.

Liverpool University has also been providing healthcare for Ebola survivors who frequently have chronic health problems including a progressive uveitis which can result in loss of vision.

I saw three patients in the MH4 clinic with total visual loss in one eye. I liaised with NGOs, WHO and the Department for International Development to discuss the provision of care for survivors, including projects to raise awareness of eye disease, thus diagnose and treat before visual loss occurs.

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

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

Ebola ROUNDUP

Ebola impacts on routine vaccinations

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

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

One year on from the start of the Ebola outbreak WHO updated the Ebola virus disease outbreak information in July 2015.
http://www.who.int/csr/disease/ebola/en/
A TRAVELLER’S TALE
Canada and the wild, wild west

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

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

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

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

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

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

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

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

The use of PGDs for private travel vaccines in England

Jane Chiodini FFTM RCPS(Glasg)

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

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

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

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

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

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

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

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

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

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

In the resources section of the information regarding PGDs on the NICE website, a PGD template has been provided and it would seem sensible to follow this format when developing a private vaccine PGD.

www.nice.org.uk/guidance/mpg2/resources

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

*See www.cqc.org.uk/content/gp-mythbuster-19-patient-group-directions-pgd-patient-specific-directions-pads

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

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

NaTHNaC published a Clinical Update in August 2015: PGD use in NHS travel services www.nathnac.org/pro/clinical_updates/pgd_travel_140615.htm

Jane Chiodini FFTM RCPS(Glasg)
**Conferences**

**NECTM6: 6th Northern European Conference on Travel Medicine**

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

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

The scientific programme will see strong global health and one health themes alongside traditional travel medicine content. New for this NECTM6 will be more informal ‘breakfast symposium’ and workshop series in expedition medicine and international medical transportation, run as day courses.

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

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

Tania John, LOC

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

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

**Coming soon...**

- **13 November 2015**
  - MASTA
  - Annual Study Day
  - Royal College of Physicians London
  - www.masta.org

- **2-3 March 2016**
  - 11th Asia Pacific Travel Health Conference
  - Wilderness and mountain medicine: Travel medicine where it happens
  - Yak and ‘N’ii Hotel
  - Kathmandu, Nepal
  - www.apthc2016.com

- **1-4 June 2016**
  - 6th Northern European Conference on Travel Medicine (NECTM6)
  - Queen Elizabeth II Conference Centre, London
  - www.nectm.com

- **28 September - 1 October 2016**
  - South African Society of Travel Medicine (SASTM) biennial Congress and ISTM 7th Regional Congress
  - Travel Health Africa - the boiling point?
  - Boardwalk Convention Centre
  - Nelson Mandela Bay, Port Elizabeth
  - www.sastm.org.za/Events/Details/15

- **14-18 May 2017**
  - CISTM15
  - Barcelona, Spain
  - www.istm.org

**Apps...**

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

Run by the Medicines and Healthcare products Regulatory Agency, the new smartphone app helps patients, carers and healthcare professionals report concerns directly to ensure the drugs are safe. Download from the iTunes App Store or Google Play for Android devices:


From the Journals

  
  DOI: 10.1056/NEJMoa1506223.


**In Memoriam**

Sad to announce that two stalwarts of travel medicine are now with us in the heavens. Their loss will be felt by many in the travel medicine community and our sympathies go to their families and friends.

**Alan Magill**

A co-founder of the International Society of Travel Medicine (ISTM) died suddenly on 19 September.

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

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

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**Introduction**

The ISTM Certificate in Travel Health CTH® will take place during NECTM6 on 1 June in London.

http://www.istm.org/certificateofknowledge
6th Northern European Conference on Travel Medicine

1st — 4th June 2016
Queen Elizabeth II Centre, London

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