Spring/Summer 2018

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
TRAVEL MEDICINE

emporiatrics

News, views and reviews

from the Faculty of Travel Medicine

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www.rcpsg.ac.uk

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Editorial

Welcome to the Spring/Summer edition of Emporiatrics.

There's a definite hint of rock'n'roll in this issue as we gear up for the summer festival season. On Page 04 our Dean Andy Green reflects on the health hazards behind the glamorous lifestyle of the stars who tour the world while, on Page 08 Linda Bailey offers advice for the thousands of fans who travel far and wide to see them. In Focus features Professor of Pharmacy Larry Goodyer on Page 06. On the education front, we take a look at a new BGTHA online course on Page 13, the second Travel Medicine Bites on Page 07 and key changes in the much-awaited malaria guidelines on Page 12. All that, plus Hilary Simons rides the rails in India on Page 10 and on Page 09 Yvonne Gibney sets off for the Silk Road in Iran.

As always, my thanks to the contributors.

Sandra Grieve

BULLETIN BOARD

Congratulations!

Dean-elect: Jane Chiodini

Jane has been elected Dean-elect of the Faculty of Travel Medicine. She is well known in the field and is involved in education as well as running her own travel health training company. She previously held the posts of FTM Secretary and FTM Director of Education. More will follow in due course.

HPS Nurse Consultant: Lorna Boyne

Lorna was recruited to the Nurse Consultant post in Travel and International Health at Health Protection Scotland (HPS) and takes up her post following a handover from her colleague Fiona Genasi, who is retiring. Lorna is well known to many in the travel health community and was previously Course Director of the Diploma in Travel Medicine and Vice Dean of the FTM. She brings vast experience and specialist knowledge to her new role.

Congratulations to Jane and Lorna and very best wishes for a happy retirement to Fiona.

RCN guidelines update

It's anticipated that the revised edition of the Royal College of Nursing publication Travel Health Nursing: Career and Competence Development: RCN Guidance (RCN, 2012) will be available during RCN Congress in Belfast 12-16 May. Analysed data was reviewed and published in an Executive Summary: Perceptions of the RCN Travel Health Competencies.
www.rcn.org.uk/clinical-topics/public-health/specialist-areas/travel-health

Pandemic!

A major exhibition on infection control during outbreaks from the 1918 flu pandemic to Ebola runs until 21 September at the Royal College of Nursing Library in London, transferring later in the autumn to RCN Edinburgh. It will also be available online - **www.eventbrite.co.uk**

Did you hear the one about …?

What do a failed South American state, a war-torn Middle Eastern country and a South Asian nation with a large refugee population have in common? It may sound like the start of a joke, but it's not funny. Venezuela, Yemen and Bangladesh have all three recently been experiencing large-scale diphtheria outbreaks, killing dozens and affecting thousands. An article by Dr Michael Edelstein and Dr Gayatri Amirthalingam for Chatham House, The Royal Institute for International Affairs is well worth a read. Diphtheria's Resurgence is a Lesson in Public Health Failure which will make you think.
www.chathamhouse.org/expert/comment/diphtherias-resurgence-lesson-public-health-failure#

Aid workers to Bangladesh

In January, NaTHNaC published information for aid workers travelling to assist with the Rohingya refugee crisis in Bangladesh after thousands of displaced people crossed the border from Myanmar. Emergency medical teams from the UK travelled to support the treatment of severe diphtheria cases in newly operational diphtheria treatment and isolation centres.
www.travelhealthpro.org.uk/news/288/humanitarian-aid-workers-to-bangladesh

Revised vaccine guidance

The third edition of Health Protection Scotland's guidance on vaccine storage and handling is an excellent resource for everyone involved in immunisation. It outlines a framework for minimum standards required for vaccines to maintain their effectiveness.
www.hps.scot.nhs.uk/resourcedocument.aspx?id=6330

Healthy vaccines

Vaccines wasted through mis-ordering, breaks in the cold chain, use-by dates exceeded and fridge failures cost the NHS thousands of pounds every year. To keep wastage at a minimum Public Health England (PHE) has produced a poster on ordering and storage, aimed at health professionals. Download it at: **www.gov.uk/government/publications/keep-your-vaccines-healthy-poster**

Nothing really changes

Public Health England is celebrating a century of marketing campaigns by collecting dozens of posters that were trying to get their message across – from 'Don't take alcoholic drinks on Mondays' to 'earnest requests' to stop spitting to current warnings on fizzy drinks, they are quite remarkable for their design quality as well as exhortations to change popular behaviour, from pre-WWI right up to the moment.
publichealthengland.exposure.co/100-years-of-public-health-marketing

Influenza 2017-18

It's been a challenging season. The main strains circulating were flu A(H3N2), A(H1N1) and Flu B. Public health agencies in all four UK countries issued weekly updates. Of concern was the level of vaccination uptake by frontline health care staff likely to be caring for people suffering from flu. Although figures for those who received the seasonal vaccine were up from last year, uptake remained low. Discussions centred on whether to make immunisation mandatory for staff. Too many frontline staff members are opting not to protect themselves or their patients.
www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-healthcare-workers-monthly-data-2017-to-2018

Letter from the Dean of the Faculty of Travel Medicine

Group Captain Andy Green FFTM RCPS(Glasg)

Lately it occurs to me what a long, strange trip it's been.

Truckin'. Grateful Dead (1970)

Over Christmas I spent some time chatting to the partner of my younger daughter, comparing notes about 'life on the road'. We both travel a lot because of work and have both been unwell in many strange places. I was left in no doubt that I was comparatively fortunate.

Which might sound odd: as a serving member of the Armed Forces I have travelled extensively around the world through my career, including to multiple austere locations and been subject to hostile fire. My Army colleagues will point out that as an RAF Officer, 'austere location' usually means a place with insufficient ice for making Margaritas or ironing my own shirt in a hotel room. In contrast people in brown uniforms apparently regard living in muddy holes as luxurious as long as the rain doesn't turn to snow. However, we do all enjoy high quality medical support, including health advice prior to travel, robust means for dealing with accidents and illness when they occur, and follow-up care on return.

The contrast to the experience of an 'Electric Warrior' was striking. He's a professional musician, a talented guitarist who has performed at the highest levels in rock bands, including a European Tour supporting Black Sabbath (Ozzy Osborne et al). Which sounds like a pretty good job. But in common with most of us who know little about other people's lives, the attraction of a superficially glamorous lifestyle rapidly wanes once you think about some of the realities – a gruelling travel itinerary, chaotic diet, disrupted sleep and fixed commitments to perform every night on stage in a new location. Every audience expects their show to be perfect.

This is difficult but achievable until someone becomes unwell. In the absence of resident medical care, the solution is usually self-diagnosis and medication. The description of the effect of a massive haematemesis secondary to non-steroidal anti-inflammatory drugs taken for abdominal pain (from his subsequently diagnosed gastric ulcer) was sobering.

So I started reflecting on my own interactions with rock musicians in the past – quite a few.

- First was a famous singer who fell down stairs on holiday and died of head injuries several days later after delayed onset of symptoms.
- As houseman, my earliest exposure to a consultant microbiologist was when he came to visit one of my patients, a guitarist who had acute hepatitis. Leptospirosis was raised as a possible diagnosis since a number of rats had been found drowned in the swimming pool after a particularly raunchy party. In the event he had hepatitis B infection from intravenous drug abuse.
- As a senior registrar in microbiology in London in the late 1980s, I met many musicians with odd and interesting infectious diseases. Most related to HIV/AIDS, but several related to intravenous drug use. Right-sided endocarditis with environmental bacteria is a signature infection (the death of a famous guitarist was due to this), while candida endophthalmitis is uniquely associated with using lemon juice to dissolve heroin prior to injection.

'Being a rock musician comes with a significantly increased risk of death from violence, liver disease and accidents.'

I decided to look a little deeper.

Surprisingly, there's a journal devoted specifically to the subject: Medical Problems of Performing Artists. The current edition has interesting (if not hard-core scientific) articles such as Heavy Metal Curse: A Task-Specific Dystonia in the Proximal Lower Limb of a Professional Percussionist" (drummers get stiff legs), and Musculoskeletal Injury Profile of Circus Artists: A Systematic Review (falling off the trapeze breaks bones).

But there have also been some serious studies looking at morbidity and mortality among professional musicians. It can be difficult to conduct such research, and the studies usually look at retrospective observational data. Plus, it can be challenging to define what actually constitutes a professional musician or artist. However, the big picture suggests stardom is associated with a doubling in mortality during the early years of fame, which reverts to age-matched norms after about 25 years (presumably reflecting survival). Being European is significantly associated with longevity when compared to American rock stars.

Here I am, on the road again.
There I am, up on the stage
Here I go, playin' star again.
There I go, turn the page

Turn the Page. Bob Seger (1973)

The reasons for ill health and early death are mostly recognisable, and reflect the historical tightrope that artists of all description have always walked between brilliance and self-destruction. Mental health issues and substance abuse are common, as are accidents (often related to alcohol or drugs). Suicides are consistently about double the matched control populations. Violence is common, but not significantly so when corrected for nationality and socio-economic group. Infectious diseases show no association with being a musician.

One analysis by music genre showed that being a rock musician comes with a significantly increased risk of death from violence, liver disease and accidents. Heavy metal music carries an almost doubling in suicide rates, both in the musicians and the people who listen to it.[i]

One study that proved ultimately disappointing (for us geeks) showed that there was no evidence for the existence of the so called 27 Club. This is the idea that age 27 is especially risky for rock musicians, given how many famous ones seem to die then – Jimi Hendrix, Janis Joplin, Jim Morrison, Kurt Cobain and Amy Winehouse. However objectively there was no difference in mortality from any other one-year cohort of musicians when over 500 deaths were examined.

The caveat to this study was that it did appear in the Christmas Edition of the British Medical Journal and did use a debatable definition of 'fame' – having a Number 1 record in the UK is not often seen as essential to true rockers – none of 27 Club was included though the Muppets were.

So how does this relate to Travel Medicine?

In many ways, once you think carefully. A Diploma in Travel Medicine student many years ago described his experiences in providing advice to a famous British band. They were domiciled in the Republic of Ireland for tax reasons, but used an island in Southeast Asia as their base for six months every year on tour.

For modern audiences, having both mobility and finances, it's not unusual to travel internationally for concerts and festivals (as at least two FTM Board members do regularly). These are commonly associated with outbreaks of infectious diseases. Clusters of meningococcal infection are regularly reported, as are gastrointestinal infections. Public Health England issued an alert in 2017 about measles outbreaks across Europe associated with music gatherings, reminding festival goers to check their MMR status.

How did my conversation with the guitarist end? I hope he was a little wiser about health risks associated with travel and touring, and knows that medical support is available but needs planning in advance. On my side, I was left wondering about yet another group of travellers who we haven't previously identified as having specific health requirements.

We finished by watching Spinal Tap: The Movie, but in a new light. The film is a comedy 'rockumentary' and succeeds because it is very close to real life and gives a graphic depiction of a band on tour. It emphasises that being a drummer is not a good career choice, noting the short lifespan and unusual modes of death. Now, I wonder: how common spontaneous combustion is in travellers?

Andy Green
Dean FTM

[i] *References on request.*

Continuing the rock 'n' roll theme, Linda Bailey has advice for festival-goers on Page 08.

IN FOCUS

Professor Larry Goodyer FFTM RCPS(Glasg)

Larry Goodyer is Professor of Pharmacy Practice at De Montfort University, Chair of the British Global and Travel Health Association (BGTHA) and Consultant Travel Health Specialist for Nomad. www.nomadtravel.co.uk

Q. As a pharmacist and academic, how did you become involved in travel medicine?

A. It's a long story going back to 1989. It started with my brother opening a shop in London, specialising in outdoor clothing and equipment, aimed at overseas travellers. Experienced in the expedition world, he saw a gap in the market for various types of medical kits and other health-related products and asked if I could help open a pharmacy in the store. This we did, and before long – with the help of my wife, who is a nurse – we started to provide vaccinations: Nomad was born.

Q. How has the provision of travel health services evolved and developed for pharmacists and pharmacies?

A. Over the last five-to-ten years it has changed enormously. Previously a pharmacist would give some advice and provide a limited range of medicines and products. Up to the 1990s, pharmacists might also obtain and dispense vaccines, but that stopped when GPs began ordering directly from manufacturers.

Recent major changes in pharmacy practice mean the pharmacist can now provide vaccination and travel health services. The most important changes were, first, the principle of immunisation in pharmacies, made possible by the introduction of a pharmacist-delivered flu vaccination service. Second, legislation allowed prescription medicines to be supplied without a doctor's prescription via a patient group direction. Having a clinical consultation room in all pharmacies was important in facilitating the development of travel health services

Q. Did you foresee how important travel medicine practice would become for pharmacists?

A. It is already an important service. With GPs increasingly under pressure to deliver their core activities, travel health is an obvious one to fall within the community pharmacy remit. Depending on the results of the Public Health England report on the provision of travel vaccines under the NHS, we could see a large movement of provision into community pharmacy.

Q. Are there any obstacles for pharmacists providing travel health services?

A. Each pharmacy planning travel health provision needs to think carefully about the type and level of service to be offered. The obstacles are: training, experience and time. Some may wish to provide only a vaccine administration service, leaving risk assessment to others. In most cases, pharmacists should probably focus on the lower risk/less complex cases (the majority of clients) which are within the limits of their training, expertise and available consultation time. There will be others who will take a greater interest in travel health and, we hope, those providing more specialist-level services will increase. These pharmacists should be encouraged to join the Faculty of Travel Medicine.

Q. As current Chair of the BGTHA, what is the link between pharmacy and the global community?

A. What I call 'Pharmaceutical Global Health' is a somewhat neglected area. This is related to the availability and quality of medicines overseas. As well as effecting the health of the local population, it is also of direct relevance to travellers, when they need to purchase medicines overseas. I am currently working on projects with the International Society of Travel Medicine Pharmacist Professional Group examining these issues

Q. What is a typical day for you?

A. I work three days a week as Professor of Pharmacy Practice at De Montfort University. This involves all the usual academic duties of teaching, research and administration. Like most academics, I consider the administration side my least favourite. The other days are spent working for Nomad, chairing BGTHA and doing lots of other things that spill over from the University.

Q. What type of holiday do you prefer?

A. I particularly like visiting friends and colleagues who live overseas and often take me to the more unusual places off the tourist routes.

Q. Do you take your own travel health advice when you travel?

A. All I'd say is that my medical kit is rather excessive!

EDUCATION

Travel Medicine Bites: Karen's story of disability and travel

An overview by David Ross QHP FFTM RCPS(Glasg) Director of Education, Faculty of Travel Medicine.

This second edition of Travel Medicine Bites has been devised for the busy practitioner to undertake a short piece of continuing professional development (CPD), an essential element of doctor and nurse revalidation through their respective regulators. Shortly pharmacists are also to undergo a similar revalidation process.

It has been designed so that you can reflect on what you have learned and record this as evidence of your participation in CPD. You can take as long as you want, but I suggest for this edition you take at least 20 minutes.

The second edition of "Travel Medicine Bites" can be accessed through the following link: **rcp.sg/TMBites**

This edition focuses on travellers who have additional needs or disability. It is a subject, that I understand very well, as my wife, Karen, became a paraplegic more than 15 years ago. However, she obviously understands the issues even more and has kindly offered to tell her story (narrated by Cathy O'Malley). She offers some top tips that travel health practitioners can use when discussing travel plans with individuals who may have underlying health problems that could impact on their travel.

As you will see, Karen used to love travel, but that all changed when she became a paraplegic and her 'paraplegic paranoia' set in.

In the modern world, there should be no barriers to travel, but for those that may have underlying health problems then good planning in good time is vital – something we all know does not always happen with many travellers.

If you have material for future editions of Travel Medicine Bites or can offer feedback as to how we could improve future editions, then do email me at: **David.Ross@rcpsg.ac.uk**

CONFERENCES

NECTM7
7th Northern European Conference on Travel Medicine
2-4 May 2018
Clarion Hotel, Stockholm, Sweden
www.nectm.com/

FTM IAPOS event
11 May 2018
The Wesley Euston Hotel and Conference Venue, London
Contact: IAPOS.admin@talktalk.net
rcpsg.ac.uk/events/iapos

Nets and Bolts
5 Jun 2018
Defence Medical Services
Lichfield
rcpsg.ac.uk/events/nets

Joint RCN NaTHNaC event 2018
Watch NaTHNaC and RCN websites for updates: nathnac.net/
www.rcn.org.uk/news-and-events/events

Pan African Travel Medicine Congress
Focus on Reality
12-15 September 2018
Cape Town, South Africa
www.sastm.org.za/TMC/Details/18

International Conference on Migration
International Society of Travel Medicine (ISTM)
1-3 October 2018
Rome, Italy
www.istm.org/ICMH2018

Faculty of Travel Medicine
Annual Symposium and AGM
4 October 2018
Royal College of Physicians and Surgeons of Glasgow, Glasgow
rcpsg.ac.uk/travel-medicine/agm-elections

Faculty of Travel Medicine/BGTHA
Joint Event
24 November 2018
De Montford University, Leicester
rcpsg.ac.uk/events/bgtha

CISTM16
5-9 June 2019
Washington DC, USA

Festival Health

By Linda Bailey

Each summer thousands of people choose to spend weekends wading through muddy fields, sleeping under canvas and eating from fast food stands in order to listen to the music they like. Some also use – or misuse – alcohol and drugs, trying to add to their experience. Most will have a great weekend and go home happy at the end of it. Others will not be so fortunate.

Other resources

- *NaTHNaC, Travelling for Carnival www.travelhealthpro.org.uk/factsheet/6/travelling-for-carnival*
- *TRAVAX, Accident prevention and personal safety www.travax.scot.nhs.uk/health-advice/general-health-advice/accident-prevention-and-personal-safety/*

Apart from the very obvious side-effects of over indulgence in alcohol or illicit drugs, there are a number of other reasons why people become unwell and need to seek healthcare at festivals, or soon thereafter.

People who are not familiar with delivering health care at festivals are often surprised by the age range of the people who attend – from newborn babies to people well into their 80s. So, we see a number of people with exacerbations of long term conditions. If the weather is warm, as well as sun-burn, heat rash and heat stroke, we often see people with respiratory conditions made worse by dust.

We also frequently see people who have left their medications at home – despite having had asthma or diabetes for years, some still turn up without their inhalers or insulin. One concern about large events relying on fast food vendors to feed attendees is the very real possibility of outbreaks of gastrointestinal illness. In the UK all events are licensed by local authorities, who usually keep a careful eye on food delivery, storage, and preparation. But there is still a risk as most of the festivals take place in fields that are home to cows and sheep the rest of the year. Even Reading Festival, which takes place less than a mile from the city centre, is on farmland.

There have been reports of outbreaks of E coli 0157, shigellosis and campylobacter at music festivals and mass gatherings. Advising festival goers to wash their hands when there are no taps on site isn't that helpful. But advising them to carry small bottles of alcohol hand-gel may protect against some illnesses.

There is also an increased risk of other infectious diseases, including vaccine preventable diseases. In the past there have been suspected transmissions of mumps and measles at music festivals in the UK among people who weren't immunised. It is certainly worth reminding young people attending festivals and events to make sure they are fully immunised well before the events.

Less common infectious diseases may also be seen. There have been reports of people contracting Leptospirosis, or Weil's disease, and Lyme disease at festivals or other large events. There were concerns in 2009 about the spread of flu, although very few large events were cancelled because of this.

It isn't unusual for people to travel abroad for music festivals. Glastonbury in Somerset, for example, attracts people from all over the world. Likewise, people from the UK travel to the USA for Coachella and Burning Man. In Europe, cheap air travel means that large festivals such as Exit in Serbia, Benicassim in Spain, Primavera Sound (alternating between Spain and Portugal), Roskilde in Denmark and Sziget in Budapest are all very accessible and attractive to UK visitors. Not all countries have the same immunisation schedules as we have so as well as ensuring travellers have had all the routine immunisations, there may be some country specific ones too.

The Lancet has a collection of articles about health at mass gatherings such as festivals and these are both interesting and informative. They cover non-communicable risks such as injuries from stampedes and poor crowd control as well as the issues discussed here: **www.thelancet.com/series/mass-gatherings**

TRAVELLERS' TALES

Iran: A journey along the Silk Road

Yvonne Gibney MFTM RCPS(Glasg) embarks on a two-part idyll in a country few travellers get the opportunity to see nowadays.

After a six-month visa application process, two rescheduled flights and hundreds of email exchanges between Merseyside and Shiraz, our plan was a trip following the fabled Silk Road. The Farsi phrase 'Arzeshe entezar ra dasht' ('it was worth waiting for') was never so true.

As British passport holders, we had to be accompanied always by a registered guide. Our initial hesitations were rapidly allayed as we got to know Reza, whose knowledge of all things Iranian past and present was as impressive as his ability to find the best tea houses and tastiest date cakes.

Similarly, preconceptions of Iran were immediately challenged when we found ourselves involved in a condom promotion event in a Teheran shopping mall. While the word condom could not be displayed, detailed leaflets on their use and sexual health messages most certainly were. We received promotional gifts and the next day our photo appeared on Iranian Instagram promoting condoms – hats off for using a woman on HRT and a man on prostate medication to promote them.

As a matter of interest, condoms are widely available in pharmacies and supermarkets, and the contraceptive pill is free for women, regardless of marital status.

From Teheran we travelled north to Tabriz in Eastern Azerbaijan. Here we visited the Blue Mosque – built in 1465, the original entrance hall remains. In the evening Turkic men gathered in public places, singing traditional songs and dancing, with hand gestures conveying the stories. We encountered similar groups in every location we visited, the performance content determined by the ethnicity of the participants.

Next stop was the volcanic Kandovan, the last cave-dwelling village on earth. Villagers live in two-to-four storey homes, some over 700 years old, carved in to cone-shaped rocks which look like giant termite mounds. It seemed so incongruous that there were net curtains at the windows and pastel painted wooded garden gates. 'Kando' means bee hive and the whole area is dotted with brightly coloured squat hives producing the sweetest honey.

On to the ancient trade route

We travelled mostly by VIP buses: cheap, reliable and comfortable. Via Zanjan and Teheran, 1,100 kms later, we arrived in Isafahan, which had been one of the most important cities on the trade routes across Central Asia. On one of the largest squares in the world, Naqsh-e Jahan, built in 1602, is the Shah Mosque (1629). It has the largest dome in the city and is covered in seven-colour mosaic tiles to give the impression of heavenly transcendence. We visited many mosques, overwhelmed by the architecture, history and calligraphic inscriptions.

Isfahan has wide boulevards, green open spaces and an artisan community specialising in miniature boxes made of camel bone. The Armenian quarter, Jola, is one of the oldest and largest in the world. Here we visited the Armenian cathedral, bought a first edition Conan Doyle book at a charity stall and drank Armenian coffee with a 93-year-old lady of Armenian nobility who told stories of being presented at court in the UK in the 1930s. Even in Iran you are never far from home!

Yvonne's journey continues next time along the fabled Silk Road.

TRAVELLERS' TALES

India: Perspectives on getting around

In part one of her adventure, Hilary Simons FFTM RCPS(Glasg) gets down to the nitty-gritty of travelling by train.

Once is not enough! Incredible India – smitten on our first visit we vowed to return, and so we did. In March 2017, we embarked on our second visit, this time with a very clear plan of what we would pack into our three-week stay. Focusing on animals and photography, it would encompass the iconic Ranthambhore (Rajasthan) and Jim Corbett (Uttarakhand) National Parks and, in my opinion, one of India's best kept secrets, Satpura National Park (Madhya Pradesh), together with whistle-stop visits to Delhi, beautiful Bhopal (Madhya Pradesh) and iconic Agra (Uttar Pradesh).

Hilary Simons

Never underestimate the length of time it takes to get from A to B in India! Our destinations were thousands of miles apart and we had limited time. Hoorah for the Indian railway system, which is gargantuan – 115,000 km of track, 750,000 railway stations and around 20 million passengers each day.

We benefited from sound advice regarding ticketing: book early for the best chance of a reasonable seat/berth. Those without pre-booked seats may find themselves in the complex wait-list, or queue system. As it sounds, you must 'wait' till a seat is available and that wait may be long and unpredictable.

Whatever your wait, take time to soak up the micro-world of a major Indian railway station. All life is there from the railway officials, smartly-dressed and exuding authority, to small children, silent, wide-eyed and wary of the station master, but seizing every opportunity to hold out their hand for food or rupee to any passing 'tourist'. We found this distressing, but our Indian friends advised an assertive 'aage jao' ('go from here') was the best option. Although uncomfortable, it did seem to work.

Travel by rail again proved to be exciting. A taxi across Delhi at dawn saw traders already setting up before the heat of the day…long wide boulevards with green lush vegetation… a fleeting glimpse of the magnificent India Gate… street children sleeping on the edge of the road… dogs scavenging and dodging traffic: and it was only 5 am. We were thankful for Manoj, who deftly negotiated the busy station, our large backpack on his shoulder, and steered us through the masses to our carriage. The poster on the carriage door confirmed this was indeed ours - Simons S aged 61, Simons H aged 60 (no secrets here)—and we settled into our 'bunk' for an eight-hour journey.

As the train moved slowly out of Delhi it was difficult to avoid eye contact through the grubby window with men, walking at the side of the track, water bottle in hand on a mission to find a suitable spot to relieve themselves. Women who have no choice but al fresco might prefer the privacy of darkness, but assault and rape are commonplace.

Toilet talk

Open defecation is a huge issue in India. The World Health Organization estimate that over 600 million people in India (around half the population) continue to defecate in the open. While we as travellers obsess about our potential to succumb to travellers' diarrhoea, over 200,000 children in India die of diarrhoeal disease every year. I engaged in some interesting discussions about open defecation with Indians on our various train journeys. The strategy of the Government scheme, Swachh Bharat Abhiyan (Clean up India) includes building 12 million toilets in rural India by 2019. However, many of those we spoke to thought this was not just about providing toilets, but rather reshaping attitudes and changing behaviours.

'Facilities' on Indian trains range from good to dire and being prepared for the dire can make the toilet experience more bearable. My top tip if travelling long distances by train in India is to carry toilet tissue, hand wipes and/or hand gel, and go early in the journey. The facilities get a lot of traffic; some trains thunder through India on journeys of many thousands of kilometres and several days! A previous visit alerted me to the perils of toilets on public transport and I was thankful I was fit enough to cope with the squat option. You need to be confident that you return to a standing position without support – holding onto the walls is not recommended. Also, in the squat position, you need to control your lower garments and your aim; splashback is to be avoided at all costs! The western toilet option was there on the trains we took, but not for the faint-hearted. Hand hygiene is essential!

The good news is that India is embracing the toilet issue on the railway system and currently upgrading older-style facilities with new, state of the art, versions.

Eat, drink and be wary…

Food choices on Indian trains vary. Chaiwallahs (selling masala chai) board the train at station stops and walk through the carriage selling their wares, shouting 'chai garma garam chai' ('chai hot tea'). Although the smell of chai and savoury offerings was delicious, we were advised by our Indian friends to avoid foods from such vendors on trains as preparation hygiene could be dubious.

On one journey (Shatabdi Express from Delhi to Katogam) we enjoyed a more familiar 'tray' service, served by courteous attendants, who later collect their tips – courtesy well rewarded. We enjoyed supper of pre-packed roti, dahl, paneer, pickles and curd, and a very welcome chai, the piping hot water supplied in a rather grubby but perfectly fine individual thermos. It seemed a 'safe' option. However, we disembarked the train via the galley area where the food trays were prepared and noted the floor was swimming with overflow from the adjacent squat toilet. We wondered what the next 24 hours would bring (we were fine).

Disembarking an Indian train can be quite perilous, particularly for the less-able. Even for us the long drop from carriage to platform was challenging. If you do not have a guide, official porters are easy to identify as they wear a badge and often a red shirt. They are sometimes known by the somewhat derogatory 'coolie', but should be addressed more respectfully as 'Sahayak'. They clamour to help you by carrying heavy luggage and finding you an official 'taxi'. In the heat and melee of the station this is 100-200 rupees (£1-£2) well spent.

Forget about driving

The roads in India, like home, vary from superb to diabolical. Rules of the road do exist (keep left, overtake on the right, stop at intersections, give way to pedestrians etc.) but appear to be only loosely applied. Two constants are a mandatory 'give way' to cows (sacred, of course, to Hindus and totally respected) and anything else that moves, and horn honking (which has a language all its own). Horns do not usually indicate aggression or impatience, as in our own driving culture – it just means 'look out, I am making a move'. After a few weeks as a passenger, the honking became reassuring as we could be fairly sure other drivers could hear that we were coming through.

Never drive yourself in India, but seek out a reputable driver with a roadworthy vehicle. Our drivers were capable and considerate, and we felt as safe as we could be. The rides were exhilarating and often breathtakingly perilous. For me (risk taker, thrill seeker) driving through India was a must-do (again) experience.

Less so for my husband who spent many hundreds of kilometres looking out of the side window, preferring not to face the action as we overtook into the path of oncoming traffic. All this with much headlight flashing and honking on both sides, accentuated swerving and a muttered prayer as the 'head on' was avoided.

The Government of India reported over 4.5 million road traffic accidents with over 1.5 million deaths in 2016, around 27.5 thousand of which were attributed to head-on collisions. On a positive note, the number of accidents in 2016 was 4% fewer than the previous year.

Next time, Hilary concludes her Traveller's Tales with Safari India style – be prepared!

Resources

- *Government of India. Ministry of Drinking Water and Sanitation. Swachh Bharat Mission Gramin (Clean India Mission Rural). www.swachhbharatmission.gov.in/sbmcms/index.htm*
- *Government of India Ministry of Road Transport and Highways Transport Research Wing. New Delhi. Road Accidents in India 2016.*
- *Trainstuff in India. Everything you need to know about train travels in India [Blog]. www.trainstuff.in/*
- *World Health Organization. Sanitation. July 2017. www.who.int/mediacentre/factsheets/fs392/en/*

CLINICAL

Guidelines for malaria prevention in travellers from the UK: October 2017

Public Health England

By Jane Chiodini FFTM RCPS(Glasg)

This key document for travel medicine advisers working in the UK has had a major overhaul in this latest edition. The essential points are listed in the Executive Summary, found at www.gov.uk/government/publications/malaria-prevention-guidelines-for-travellers-from-the-uk.

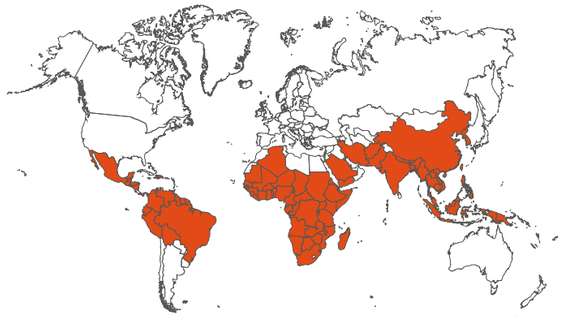
The authors of the guidance wrote this document on behalf of the Advisory Committee for Malaria Prevention (ACMP). They stated that ACMP undertook an in-depth review of malaria risk for travellers to Southeast Asia, South America, parts of the Caribbean and south Asia, which resulted in substantial changes to advice where malaria is present. Many of these areas have now been judged to be below the threshold for advising chemoprophylaxis. This doesn't mean that there is no malaria risk at all, but the risk is sufficiently low that malaria tablets are not now advised for some destinations.

The full methodology is explained in appendix 1D (pages 92-93). For all malarious countries though, the advice regarding awareness of risk, bite prevention and prompt diagnosis remain extremely important. In addition, the guidance explains that long term visiting friends and relatives (that is, those going for six months or longer) run a higher risk of catching malaria than short term travellers to the same location.

Risk of developing severe or complicated malaria in those infected is higher in certain groups such as the elderly (over 70 years), the immunosuppressed and those with complex co-morbidities, and pregnant women. These groups should still not be offered antimalarials routinely where bite avoidance is now only recommended, but offering antimalarials may be considered in exceptional circumstances and of course, expert advice can also be taken in these situations from the Malaria Reference Library (MRL) fax service.

Reference:

- Chiodini PL, Patel D, Whitty CJM and Lalloo, DG (2017) Guidelines for malaria prevention in travellers from the United Kingdom, London: Public Health England; October 2017.



NaTHNaC and TRAVAX

The guidance states that the final decision on whether or not to advise chemoprophylaxis rests with the travel health adviser and the traveller after individual risk assessment has been performed.

Over 30 countries have had a change of advice to 'bite avoidance only' where the previous guidance advised chemoprophylaxis. The full list is found on pages 39-47.

To complement this change, NaTHNaC has substantially revised and re-designed their malaria maps along with a new colour coding to reflect the different levels of risk from 'no risk' to 'high risk'. These are included in the Guideline document from pages 101 to 139.

There is an important statement in the Guidance on page 8, repeated on page 12, that says: 'We recommend health professionals stick to using one resource for country-specific malaria recommendations to optimise consistency of advice. Whilst we recognise that other sources of advice are available, healthcare professionals working in England, Wales and Northern Ireland are advised to use the ACMP guidelines as the preferred source of guidance for malaria prevention.'

CLINICAL

The ABC of Travel Health

Mike Townend FFTM RCPS(Glasg) has details of a new e-learning course on the basics for travel health advisers, available at: www.abcoftravelhealth.com

by Mike Townend FFTM RCPS(Glasg)

The British Global and Travel Health Association's new e-learning course in travel medicine, launched on 18 November 2017, can be seen as a comprehensive introduction to the field – or as a refresher course for doctors, nurses and pharmacists who may not wish or be able to undertake other training courses.

Students work in their own time and set the pace anywhere a computer, tablet or smartphone is available. It may encourage some to consider attending travel medicine symposia or conferences, while others may go on to the College's Diploma course and/or take the MFTM examination to gain full Faculty membership.

It consists of 10 'mini-courses' which can be undertaken in any order. These cover such topics as:

- information gathering
- risk assessment
- prevention of illness in travellers, including vaccinations and malaria prophylaxis
- travellers with special needs
- managing illness abroad and on return
- setting up and running a travel clinic, both in the NHS and privately.

Each mini-course contains a variable number of lessons on specific areas within the topic, and individual lessons or groups of lessons are followed by self-assessment questions with immediate feedback on the answers.

A certificate is available on completion for annual appraisals and revalidation purposes. Continuing professional development (CPD) recognition has been granted by the Faculty of Travel Medicine (FTM), Royal College of Physicians and Surgeons Glasgow.

Two of the mini-courses contain a small number of free lessons which can be accessed as samples of the course content following registration, but before committing to payment.

Editors are Eric Walker (Hon Professor) and Mike Townend (Hon Senior lecturer) in Travel Medicine and Global Health at the University of Glasgow. All 20 contributors are highly qualified experts in their own particular travel health fields, the majority being FTM Members or Fellows. Software was written specifically for the course by an expert in both education and writing computer code

Be quick for a discount!

The course fee is normally £100, but available currently at discounted 'launch' rate of £70. You can also apply for a discount for groups of three or more (for example, colleagues in the same clinic), and for university or college students.

More information and registration at: www.abcoftravelhealth.com

We acknowledge an Independent Educational Award from Glaxo Smith Kline to cover the cost of development of the software on which the course is based. They have had no input into or influence on the course content.

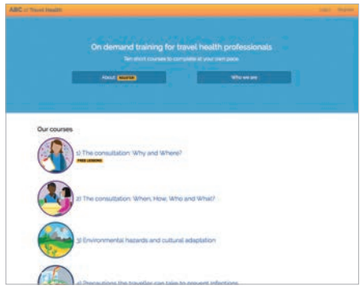


Figure 1: Logging on will take you to the welcome screen

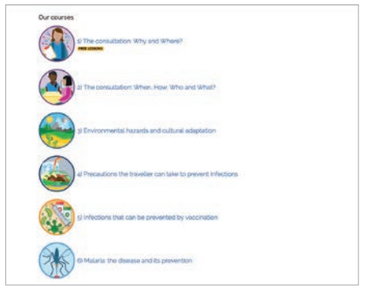
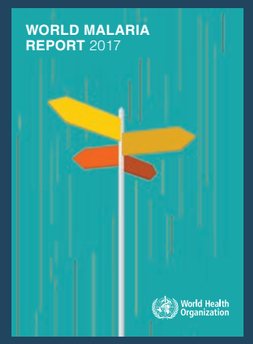


Figure 2: Access to free lessons

Figure 3: A portion of one of the free lessons

New Publications



WHO World Malaria Report 2017

The decline in malaria numbers since the millennium has stalled. In 2016 there were 216 million cases, an increase of five million cases recorded in 2015. There were 445,000 deaths similar to 2016.

www.who.int/malaria/publications/world-malaria-report-2017/en/

ABTA Travel Trends 2018

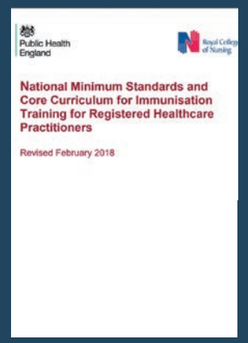
In spite of a challenging UK economy, demand for holidays is likely to remain strong in 2018. It features trends set to influence holidaymakers' habits and the 12 destinations to watch.

www.abta.com/assets/uploads/general/ABTA_Travel_Trends_Report_2018.pdf

UK All-Party Parliamentary Group on Malaria and Neglected Tropical Diseases (APPG) Annual Report.

This covers the period September 2016 to September 2017, with reference to key events outside of this period that have influenced the APPG activity. This will inform the APPG's work over the coming year.

Not yet available online. Copy available from the editor on request.



National Minimum Standards and Core Curriculum for Immunisation Training for Registered Healthcare Practitioners. Revised February 2018

To be succinct, it does what it says on the label. Essential reading.

www.gov.uk/government/uploads/system/uploads/attachment_data/file/679824/Training_standards_and_core_curriculum_immunisation.pdf

From the Journals

Johnson N, Sandys N, Geoghegan R et al. (2018) Protecting the health of medical students on international electives in low-resource settings, *Journal of Travel Medicine, 25 (1), 1 January 2018. doi.org/10.1093/jtm/tax092*

Giancarlo Ceccarelli G, Vita S, Riva E et al (2017), on behalf of the Sanitary Bureau of the Asylum Seekers Center of Castelnuovo di Porto. Susceptibility to measles in migrant population: implication for policy makers, *Journal of Travel Medicine, 25 (1) January 2018. doi.org/10.1093/jtm/tax080*

Tickell-Painter M, Saundersa R, Maayanb N, et al. (2017). Deaths and parasuicides associated with mefloquine chemoprophylaxis: A systematic review, *Travel Medicine and Infectious Disease 20 (2017) 5–14. dx.doi.org/10.1016/j.tmaid.2017.10.011*

Ahuka-Mundeke S, Casey RM, Harris JB et al (2018). Immunogenicity of Fractional-Dose Vaccine during a Yellow Fever Outbreak – Preliminary Report, New England Journal of Medicine nejm.org. DOI: 10.1056/NEJMoa1710430.

Savelkoela J, Binnendijka KH, Spijkerb R.et al (2018). Abbreviated atovaquone-proguanil prophylaxis regimens in travellers after leaving malaria-endemic areas: A systematic review, *Travel Medicine and Infectious Disease 21 (2018) 3–20. doi.org/10.1016/j.tmaid.2017.12.005 www.travelmedicinejournal.com/article/S1477-8939(17)30222-3/pdf*

Hamer DH, Angelo K, Caumes E, et al. (2018) Fatal yellow fever in travelers to Brazil, 2018. *MMWR Morb Mortal Wkly Rep 2018;67:340-341. dx.doi.org/10.15585/mmwr.mm6711e1. (N.B. Official citation)*

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