The major outbreak of ebola in West Africa over the past months has helped focus our minds on the seriousness of many tropical diseases and the ease in which they can travel from place to place across our planet. We have seen National Isolation Units throughout Europe being dusted off for the first time in many years to be ready to provide suitable care for and possible cases of a foreign haemorrhagic fever reaching our shores. Every patient returning home ‘from Africa’ is suspected as a possible threat despite the fact that ebola is a relatively difficult disease to contract under normal circumstances. Unfortunately the more common serious and infectious diseases may be over-looked under these circumstances with devastating effects for patient and practitioner alike.

As practitioners involved in providing healthcare for the international traveller we have three clear periods of time where we have the opportunity to assist our patients to help ensure that all they return home with is good memories. This can be identified as the 3 Ps of travel medicine; pre (departure), present (overseas) and post (exposure).

The Pre-Departure slot is probably the most clearly defined and the one where perhaps we can have a degree of confidence. The patient presents with an understanding that you will know a significant amount about the risks which they could encounter during their itinerary. They will have usually done loads of preparation themselves (on Dr Google) and so one danger is that in fact they know more then you do about what health precautions should be in place. That is embarrassing! The questions a practitioner should ask themselves when seeing any international traveller include the Who, What, When, Where, Why and How of identifying the risks.

- **Who** (alone or in a group, females, males, mixture)
- **What** do they expect out of the trip (holiday, business, emigration, taste local foods, etc)
- **When** are they going (time before departure, monsoon, or dry season)
- **Where** (country and also region specific itinerary)
- **Why** are they going (sea and sun, trekking, adventure sports, climbing Kilimanjaro, contact with the locals, etc)
- **How** are they travelling (flights, local transport, hiring cars, motorbikes, etc)
Risk analysis

A full risk/benefit analysis then needs to be considered regarding the required/recommended vaccines and cover against other potential risks including malaria, dengue, chikungunya, cholera, meningitis, Japanese encephalitis, etc.

Some vaccines will be excluded because of cost (e.g. rabies, Japanese encephalitis, meningitis, etc) or time frame (time needed to produce protective antibodies). If the traveller only has time for one visit then perhaps only the single dose vaccines will be possible (yellow fever, polio/tetanus, Hep A/typhoid). However, it is essential that the practitioner does explain the risks from the other diseases to which they may be exposed during their itinerary and how these would perhaps usually be recommended for this trip. Always allow the patient decide regarding the available vaccine cover and clearly document that this was discussed so that a paper trail of advice given is maintained against the records. Medical practices have been sued because certain vaccines were given but it is likely we will also see legal cases in the future to explain why vaccines were not given.

Yellow fever – change

One specific change relates to the recommendations for the administration of the yellow fever vaccine which have changed in recent days and practitioners need to be aware of how this may affect their advice for certain patients. The disease is expanding in South America and yet in East Africa some of the countries, historically regarded as at-risk destinations, are no longer seen in this light by WHO and CDC and other international authorities.

http://www.who.int/mediacentre/factsheets/fs100/en/
http://www.cdc.gov/vaccines/vpd-vac/yf/default.htm
http://www.nathnac.org/pro/factsheets/yellow.htm

In June 2016 the International Health Regulatory body is due to meet to ratify that the current 17-D Yellow Fever vaccine actually provides life-long cover and that subsequent doses are not required to maintain protection.

Malaria

The UK Malaria Advisory Group has recently issued revised guidelines for protection against malaria for UK travellers and that also makes quite interesting reading in that they have altered their recommendations for many countries.


When one of our travellers is Present Overseas they may quite frequently require urgent medical care. This can be due to an accident or a disease process (sun stroke, fever, diarrhoea, skin rash, headaches, just bitten by a dog, etc) or due to a change in their plans (do I need malaria prophylaxis, etc) or some other cause (my bag has been stolen and I need documentation showing my vaccines). Having access to a 24/7 emergency cover service can provide a great deal of comfort to the traveller and occasionally may be instrumental in averting a life-threatening situation. When a practice deflects this emergency cover away to a third party service (Doc-On-Call type facility) that does little to assist in the healthcare of their patient. Being in a position to talk through a problem with your patient will be a very positive experience for both parties though of course the legal responsibility for the advice given is the same as for the face-to-face consultation and this does need to be borne in mind. Documentation of all such interaction needs to be clearly recorded and patients must be advised to seek local medical care if at all possible.

When the patient attends for the Post travel consultation it is important to again go through the travel medicine mantra (who, what, where, when, how) to get an idea of what exposure risks they may have encountered. Knowing their specific symptoms will help focus your mind but just be aware that many tropical diseases can present with the most obscure clinical presentation. In the majority of cases an imported disease process will present days, weeks or a few months after a traveller returns home. However in some cases this can be very significantly extended and the early milder symptoms can be passed over by the patient and practitioner alike.

In any general practice throughout Ireland there will be a significant number of their patients with IBS. This has probably been diagnosed on their symptoms and perhaps even followed up with the obligatory full colonoscopy! The question as to whether or not these symptoms could be associated with a parasitic infestation from their overseas trip some time previously is seldom considered and even then finding a laboratory willing, capable and experienced in testing for ova and parasites is a rarity.
those who have had fresh water exposure while overseas in the tropical (usually from Africa in our patients) should be considered as possible cases of schistosomiasis to account for their less than usual symptoms. Schistosomiasis is usually asymptomatic in at least 25% of those infected and may only become a serious clinical issue some years later when all have forgotten that swim in Lake Malawi back in 2005.

Most patients with malaria will present kindly (for the attending practitioner!) with fever, sweating, shivering and an uncomfortable headache within a few weeks following their trip with a skin tan that helps prompt the attending doctor! However, that is not always the case and some patients may only present after the excitement of their trans-African safari is just a dim distant memory and the tan has long faded!

Leishmaniasis
The patient who attends with the ‘un-healing mosquito bite’ after their trip to Greece or Spain may be missed as a case of cutaneous Leishmaniasis by the unsuspecting practitioner who is unaware of the risks in those parts of the world. However it is also worth remembering that within the past year new cases of malaria have been reported in Greece and cases of schistosomiasis in Corsica which makes it seem that perhaps regions so much closer to home are becoming more tropical!

From the transport point of view, with the world becoming smaller and as patients are moving from point A to point B within hours and well within the incubation periods for many serious diseases foreign to Europe, it is essential that all patients attending for consultation are asked the simple ‘have you travelled recently’ as a routine part of their consultation history. If the answer is positive (even if only within temperate climates or to another region of Ireland (‘yes, I went hiking in Glendalough a few weeks ago’) this may have a profound effect on your differential diagnosis. The urban based business patient may have contracted Lyme disease in Ireland to account for their chronic fatigue or perhaps Weil’s disease (‘I was on a farm (or golfing) last week’) which would explain their high fever and profuse sweating etc. Thinking outside the normal constraints of daily practice is what makes medicine and nursing such great professions but a closed mind lays the foundation for disaster.

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