

TAISTEAL



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NEWSLETTER

ed. C. Maguire

*The Travel Medicine Society of Ireland
wish all our members
a very Happy Christmas and a
Prosperous New Year*



We look forward to seeing you in 2016

LOOKING AFTER EXPATRIATES.

An 'expatriate' is defined as a person taking up residence in another country for occupational reasons, returning to their original country when their business is completed. As such, expatriates form a distinct subgroup of patients seeking Travel Medicine advice, quite different to the majority who are going on holiday. Expatriates can belong to Government (diplomats), non-governmental organisations (aid workers, missionaries) or private sector companies (civil engineers, oil workers, finance professionals).

If our aim in Travel Medicine is to preserve the health of our patients while they are overseas, then the challenge of doing this in the expatriate subgroup requires a different emphasis in parts of the consultation, particularly around psychological preparation. Three kinds of pre-departure intervention should be considered: medical, psychological and security/safety.



Pillar 1 – Medical Checklist:

- Vaccines
- Malaria prophylaxis, if indicated
- Advice regarding food, water, insect bite minimisation
- Pre-travel dental check-up
- Pre-travel medical check-up
- Insurance

Patients often take the high standard of dental care available in Ireland for granted. Patients should be encouraged to alert their Irish dentist to the fact that they will be abroad for an extended period. In some cases this enables the dentist to offer the patient pre-emptive treatment which will avoid issues arising several months later while abroad. Good advice regarding adequate levels of insurance for both travel and health is available here: <https://www.dfa.ie/travel/know-before-you-go/travel-insurance-and-health/>

Pillar 2 – Psychological Preparation:

As health professionals practicing Travel Medicine, we are quick to address issues around vaccines and malaria prophylaxis, but spend far less time on assessing how prepared the patient is for the challenges of adapting and coping with the new environment in which they will spend months or years. At a minimum, even a brief handout given to the patient can alert them to the well-described stages of cultural adaptation (akin to the stages of grief described by Kubler Ross) that lie ahead of them.

Stages of cultural adaptation:

| Stage of journey: | Phase: | Characterised by: |
|-------------------------|----------------|---|
| Before going | Anticipation | Excitement and apprehension |
| Early days post arrival | Honeymoon | Everything feels new and interesting – the expat feels like a spectator |
| Some days/weeks later | Post-honeymoon | The new culture is intruding in negative ways on the expat's lifestyle; homesickness occurs |
| Later | Adjustment | Aspects of the new culture are accepted as part-and-parcel of the new environment |
| Leaving | Exit | Stress of leaving a hard-won social network of friends in the adopted society |
| After returning home | Re-adjustment | 'Reverse culture shock' – finding some aspects of the home society are now unwelcome (e.g. people can seem to be less friendly). Tiredness. |

Not unlike uncompleted grief processes, the journey through the stages of cultural adaptation remain uncompleted in some expatriates, who can find themselves becoming so critical of a host country that adjustment never occurs and what may have been intended to be a placement lasting months or years ends in a matter of weeks.

Key coping strategies designed to avoid a premature return home:

- Language training (to limit cultural alienation)
- Realistic expectations (job, climate, accommodation, environment)
- Adequate sleep
- Regular exercise
- Maintaining contact with home/family
- Having something concrete to come home to

Language training can be undertaken following arrival in-country and even if done on a regular basis, however modestly, can have a transformative effect on the expatriate's perception of their new environment, by greatly reducing feelings of alienation. It also helps enormously if the expatriate has had the opportunity to talk to other expatriates who are already living at their destination. This allows for realistic expectations to be set around their upcoming working environment, local culture, standard of accommodation and supports, or the lack of them, that are in place locally.

Pillar 3 – Security/Safety:

Threats to health from road traffic accidents or violent theft are not insignificant in the case of those who undertake prolonged residence in some countries. It is well worth encouraging patients to visit the following webpage maintained by the Irish Dept. of Foreign Affairs: <https://www.dfa.ie/travel>. Apart from providing regularly updated country-specific safety and security advice, patients are encouraged to register their presence in their adoptive country via that webpage. This provides the Irish embassy responsible for that country with the ability to assist Irish citizens more efficiently in the event of problems related to natural disasters or political instability. In addition, patients will become more rapidly introduced to existing expatriate networks and supports, through embassy-sponsored cultural events.

Summary

Maintaining the health of expatriate patients has a particular emphasis on psychological well-being. A structured approach in the consultation that addresses not only medical but also psychological and security/safety issues is necessary if all of the patient's Travel Medicine needs are to be adequately met.

Dr. Simon Collins



6TH NORTHERN EUROPEAN CONFERENCE ON TRAVEL MEDICINE



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TROPICAL MEDICINE COURSE REPORT

I had the great pleasure of attending the TROPMEDEX tropical medicine excursion to Ghana in West Africa from November 26th to December 5th. This course is organised and delivered by Dr. Kay Schaefer (Figure 1), an experienced consultant in Tropical Medicine working in Cologne, Germany, whose PhD was based on research on schistosomiasis and leishmaniasis in Africa. His extensive experience of living and working in sub-Saharan Africa makes him the ideal leader for medical expeditions to the continent. He has been offering courses in Kenya, Tanzania and Uganda for over 20 years, but this was his fourth successive year to guide healthcare professionals on an expedition to Ghana.



Figure 1. Dr. Kay Schaefer, Course Director

I have introduced a special study module entitled "Tropical Infectious Diseases" into the undergraduate medical curriculum at NUI Galway, and this course provided a helpful refresher in tropical diseases as I prepared learning materials for this module in semester 2. I joined a delightful group of 12 doctors, mostly GPs, infectious disease experts, travel medicine specialists and consultant microbiologists, on our 10-day medical tour of southern Ghana. My connecting flight from Heathrow landed 3 hours behind schedule so we arrived at our hotel in Ghana at midnight. A driver collected us from the airport and throughout the trip we enjoyed very reliable transport with an English-speaking driver in an air-conditioned bus. The roads in Ghana are of very variable quality and it takes some skill for drivers to safely avoid the numerous potholes on some of the secondary roads.

On day 1 of our excursion, following a morning lecture on schistosomiasis, we visited Dangme East District Hospital where local doctors presented cases of patients with malaria and sickle cell disease to the group. We stayed at a riverside hotel that night and enjoyed a seafood buffet meal on the shores of the Volta River. The following morning we went on a river cruise,

stopping off to visit a vibrant fishing village on the way (Figure 2), and learning how the river acts as a habitat for schistosomiasis (bilharzia). So many of the locals are chronically infected and we learned that the national mass drug administration programme which covers schistosomiasis, river blindness, lymphatic filariasis, and trachoma does not reach every village as it should. Dr. Schaefer gave lectures on malaria and cutaneous larva migrans and we saw cases of the latter at the nearby Akosombo hospital later that day. We were careful to avoid walking barefoot once we had seen how unpleasant this hookworm infection can be! Fortunately it is easily treated with Praziquantel. Consider it in your returned travellers presenting with an intensely pruritic serpentine rash on the soles of their feet especially.



Figure 2. A fishing village on the shores of the Volta River

The following day we visited Aburi Botanical Garden and learned about the native trees of Ghana and their medicinal properties. We then had a tour of the Cocoa Research Institute to learn how farmers are assisted in growing this important crop, from which many fine products including cocoa butter and chocolate are derived. Even though Ghana is currently considered free of Ebola virus disease, it is not free of dengue infection which, according to Dr. Schaefer, is often under-diagnosed in Africa. Your febrile patients who return from Africa may have contracted dengue but you must of course exclude malaria first. Buruli ulcer, a necrotising skin infection caused by *Mycobacterium ulcerans*, is very common in Ghana, and we received a lecture on the topic before visiting a missionary hospital in Agogo where we saw many patients with Buruli ulcer, chronic hepatitis B and tuberculosis.



Figure 3. A roadside public health message about malaria

This took us to the second city of Ghana, Kumasi, whose sprawling market is possibly the largest in West Africa (Figure 4). We walked through the market the following day with two local guides and Dr. Schaefer, and we were treated to a tantalising display of local meats, fish, spices, and just about every product imaginable; the intense heat and noise just added to this unforgettable sensory experience. A guest lecturer from the USA gave lectures on WHO travel vaccines and travellers' diarrhoea on day 5, before the group visited a museum and palace dedicated to the colourful Kingdom of Ashanti, currently a sub-nation state within Ghana. This was one of many examples of how this expedition provided valuable context for our understanding of tropical diseases; to gain an appreciation of how tropical diseases are transmitted one needs to understand the environment, the people, their culture and health beliefs.



Figure 4. The market at Kumasi

From the still waters of the Volta River where schistosomiasis is endemic, we then learned about onchocerciasis, or river blindness, which is associated with fast-flowing rivers and spread by the black fly. The group joined public health officials as they did active case finding in a village affected by the disease. It was reassuring to see an Ireland Assist truck distributing free bags of clean water to the villagers, who jointly celebrated the recent passing of a local person and our arrival in the one ceremony; some of our group even joined in the celebrations by dancing along with the locals! The warmth and exuberant good humour of the Ghanaian people impressed me deeply and we were very privileged to be able to meet and talk to many local people throughout this trip.

Ghana suffered a large outbreak of cholera in 2014 and Dr. Schaefer gave us an excellent update lecture on this disease. Later that night we arrived at a delightful beach resort close to the fishing village of Brenu, and the party shared a delicious seafood feast on the beach with only a bonfire for light. I have an amateur interest in ornithology and this part of the tour was a real treat for me (Figure 5), as I saw hooded vultures, black kites, hornbills, weavers,

and cattle egrets (occasionally seen in Ireland) for the first time in the wild. We even saw fruit bats a few days later as we arrived into Ghana – yes the same fruit bats which are thought to be reservoirs for Ebola virus disease!



Figure 5. A cattle egret following a herd of goats in Brenu

Lymphatic filariasis is hyper-endemic in the Cape Coast region of Southern Ghana and we saw patients with varying degrees of severity of this distressing condition on day 7. Most had already been treated for the disease but we gave advice to the patients through an interpreter about the importance of foot hygiene to prevent ulceration. The tour guide who took President Barack Obama around Cape Coast Castle, which was a staging post for the transatlantic slave trade, also guided us through the slave dungeons and told of the horrific treatment of the slaves at the hands of the cruel slave traders. I had learned about the slave trade while visiting the Gambia in 2009 but we all found this guided tour very informative and moving.

Day 8 brought a welcome early rain shower (daytime temperatures were a humid 30 degrees every day) which cleared on time for our lecture on leprosy before we went on rounds with an experienced dermatologist at the local Ankafu leprosy hospital. This was a good day for physical activity as we got to go on a guided walk through the rainforest at Kakum National Park and learn about botanical medicine which is widely practised in Ghana. My last forest canopy walk was in Brunei in 2013 but this one in Ghana was even more exciting and there were cheers for each participant as he/she completed the crossing on a rope bridge which apparently can take the weight of two elephants! Later that evening we went on surgical rounds with a dynamic local general surgeon who brought us to patients on the wards with an acute abdomen from a typhoid-related gut

perforation, volvulus, and osteomyelitis. The same doctor provides medical assistance to ill international travellers in conjunction with International SOS who sometimes fly into a local air strip to evacuate seriously ill travellers. One of the highlights of the trip was a guided walk through the fishing village of Brenu, where we were greeted by the local chief, before being driven back to the capital Accra.

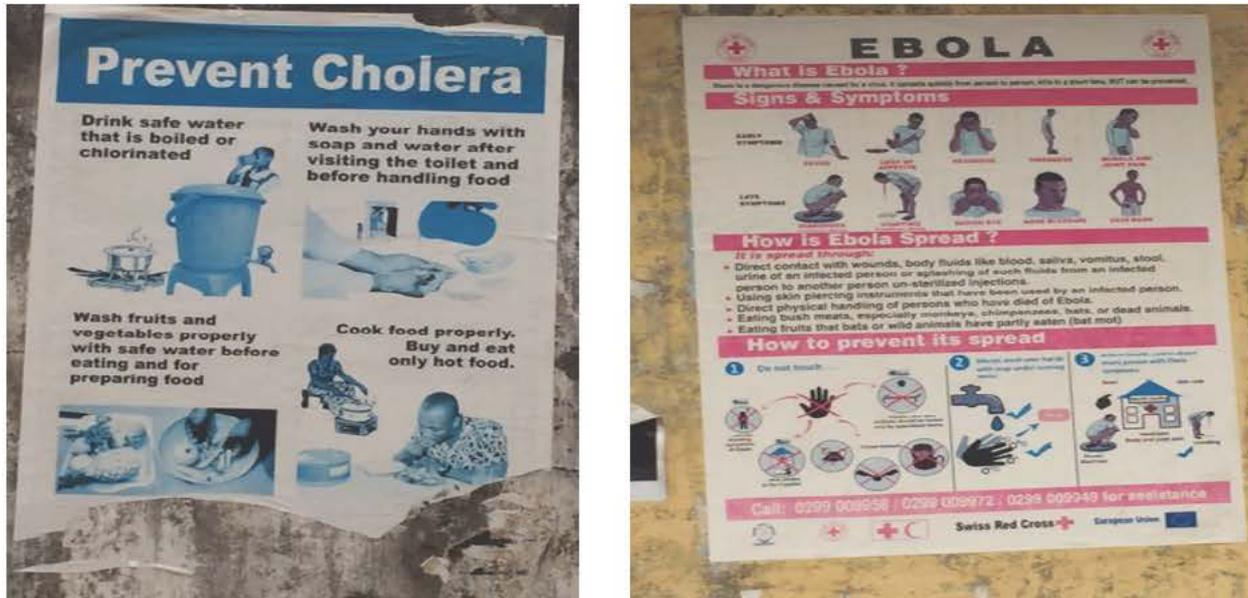


Figure 6. Information posters on cholera and Ebola in Brenu fishing village

On the final day of the expedition we had a practical laboratory session in a very modern private laboratory in Accra. This was a good opportunity to practice thick and thin blood films and brush up on our microscopic diagnosis of various parasites. Overall, this was a most enjoyable learning experience and I cannot speak highly enough of Dr. Schaefer and his team. His punctuality and organisation were outstanding and he gave us all a lasting insight into the culture and diseases of this fascinating country. I recommend that all travel medicine clinicians who also like to travel complete a medical excursion such as this if they get the opportunity. You will find that the pre-travel health advice you give to patients will be more specific and well informed and ultimately more effective at preventing tropical infectious disease. Ghana has enormous potential as a tourist destination, being currently ranked as the fourth most peaceful country in Africa. I hope you get a chance to visit there and I hope that the people of Ghana will have a brighter future.

Dr. Gerard Flaherty

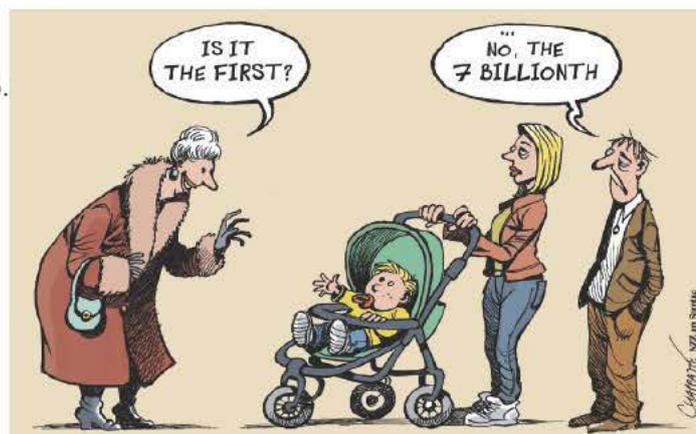
WHO IS THE YOUNGEST PERSON ON THE PLANET?

Were you the youngest person on the planet at the moment of your birth? Statistically, that is very doubtful. If you are aged thirty today, you were born in 1986. In that year, 166.7 million babies were born in the world, giving a birth rate of 5.3 babies arriving every second. Three percent of those were multiple births. That means there is an 82.7% chance of two births arriving at the same time. If you know the precise second you were born, there is only a 17% chance that you were first and you would only hold that spot for 0.2 seconds!

Dr. Conor Maguire

Ref:

1. World Development Report 1986.
2. The Actuary, issue Sept 2015.



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BLUE AND GREEN WITH ORANGE IN BETWEEN!

At the recent TMSI meeting In Liffey Valley, Dublin, there was a lively debate on the merits and hazards of different size needles. The immunisation guidelines for Ireland recommend that all vaccines given to adults and children of any age should use a 25 Gauge (Orange) or a 23 Gauge (Blue) needle providing it is at least 25 mm long. There are two exceptions:

1. Where an infant weighs less than 3 kgs, the shorter 16 mm (orange) needle should be used.
2. Obese adults require a longer 40 mm needle. In practice, this could involve using a 21 Gauge (Green) needle.

The Irish Guidelines, broadly agreed with CDC recommendations, in that shorter needles may be used in small, thin individuals, and longer needles should be used in larger adults. Many vaccines come in pre-filled syringes so the question does not arise, however some come with solvent and phial and two needles. Manufacturer's recommendation is to use one for drawing up and one for injecting. Many of these vaccine packs contain the shorter 16mm orange needle. In that case, guidelines would suggest it be used to draw the vaccine and the enclosed blue needle or another 25mm orange needle be used to inject.

Guidelines are exactly that: they are not prescriptive. The key point to remember is to administer the correct vaccine at the correct dose, in the correct site. The vaccine must be delivered into muscle and not fat or subcutaneous tissue. Gluteal muscle is no longer used for that reason. Pinching and gathering up the skin makes a subcutaneous injection more likely. If using a shorter needle, make sure to spread the skin flat. Of course if your intention is to give an intradermal vaccine then a different set of guidelines apply.

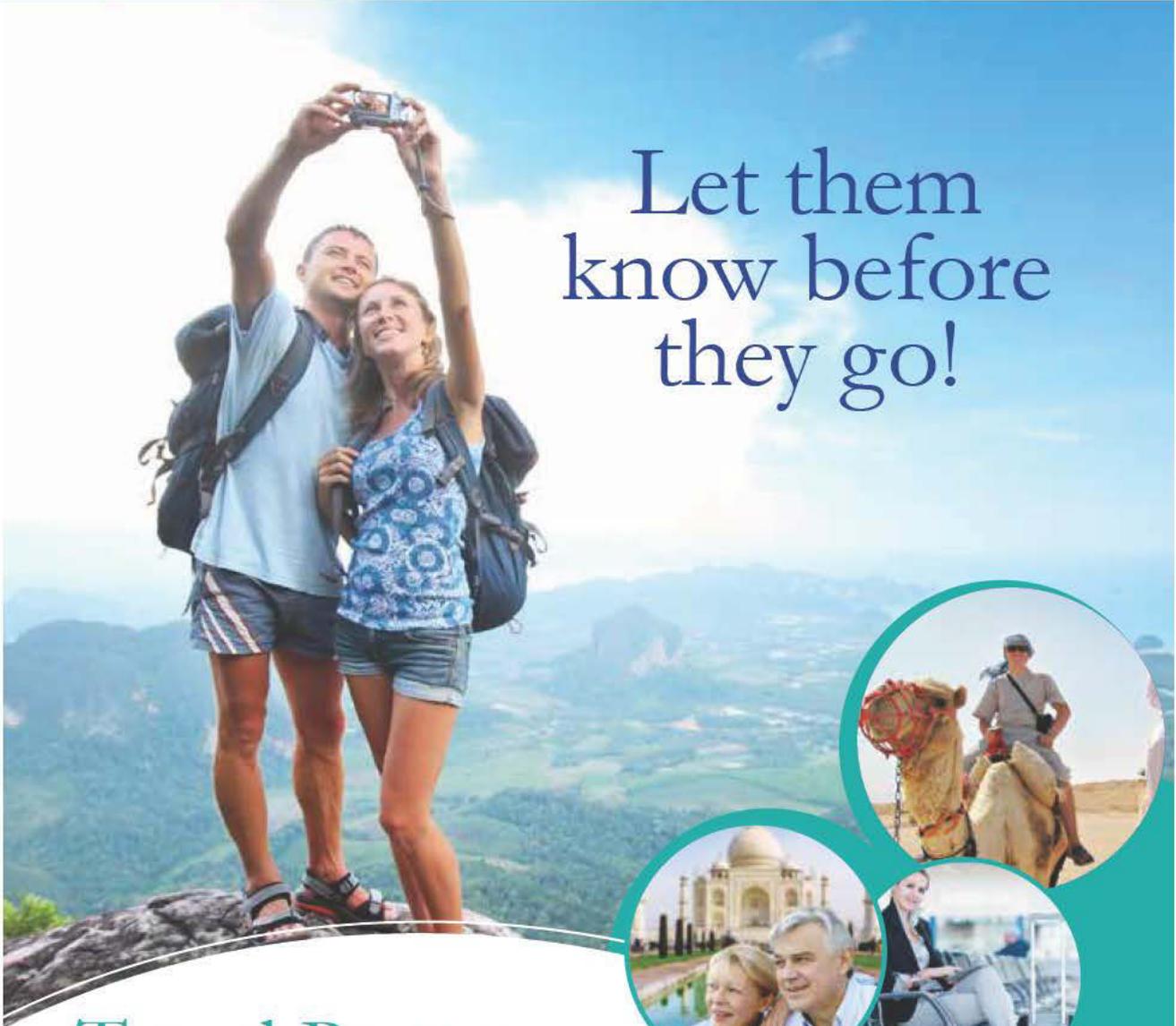


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1. Immunisation Guidelines for Ireland, Chapter 2, p 15-16.
2. www.CDC.gov, Vaccination Administration, Recommendations and Guidelines.
3. Guidelines for Vaccinations in General Practice, July 2015, published online by HSE.
4. Manufacturer's Vaccine Data Sheets.

Dr. Conor Maguire





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CHIKUNGUNYA – AN EMERGING INFECTIOUS RISK FOR TRAVELLERS

- ✿ Chikungunya is a Makonde word and translates as “disease that bends up the joints”.
- ✿ Chikungunya virus is an alphavirus which is spread by the day-biting *Aedes aegypti* or *Aedes albopictus* mosquitoes.
- ✿ *Aedes* mosquitoes prefer to bite during daylight and early evening in urban and semi-urban settings.
- ✿ The virus can be transmitted in a human-mosquito-human cycle.
- ✿ Since 2004, it has caused millions of cases in the Indian Ocean region (including the island of La Réunion), and has emerged in Europe, the Middle East and Pacific region.
- ✿ In December 2013, local spread of chikungunya was identified in the Americas, on the island of St. Martin, and has since spread to many countries in the region.
- ✿ Sustained transmission of chikungunya in the Caribbean could lead to its rapid spread around the world.
- ✿ The clinical presentation of chikungunya is similar to dengue infection.
- ✿ The incubation period is short at about 4 days.
- ✿ Symptoms include abrupt onset of fever, myalgia, headache, and a maculopapular rash.
- ✿ Polyarthralgia is a prominent feature of the infection and typically involves smaller peripheral joints in a symmetric distribution.
- ✿ Tenosynovitis also helps to distinguish the infection clinically from dengue.
- ✿ Joint symptoms may persist for months or even years in rare cases.
- ✿ Although death rarely occurs, serious complications include hepatitis, myocarditis or Guillain-Barré syndrome.
- ✿ More severe outcomes typically occur in neonates, elderly patients and those with underlying diseases such as diabetes.
- ✿ Laboratory abnormalities include thrombocytopenia and leukopenia.
- ✿ Diagnosis is largely clinical in the context of a travel-related exposure history.
- ✿ Anti-chikungunya IgM antibodies are elevated 5 days after the onset of symptoms; acute and convalescent IgG levels are also useful if serology is performed early.
- ✿ Treatment is supportive and no antivirals are effective so far.
- ✿ Paracetamol may be safer than NSAIDs for the symptomatic treatment of polyarthralgia if dengue infection is a possibility.
- ✿ Disease-modifying anti-rheumatic drugs have been used in some cases of chronic arthritis.
- ✿ Currently no vaccines are available but there are some under development.
- ✿ Travellers to endemic areas should be advised about mosquito bite prevention.

Dr. Gerard Flaherty

THE DANGERS OF HENNA TATTOOS.

A 22 year old student returned from a holiday in Morocco where she and her friends got henna tattoos on their arms and legs. One week later, she presented with an acute dermatitis, in the pattern of her henna artwork. This was itchy and painful and caused a raised, inflamed, scaly rash, seen in the photo below.

Henna is a paste made out of crushed leaves and twigs of the henna plant (botanic name: *Lawsonia inermis*). Dried leaves are mixed with water or a weak acid such as vinegar or lemon juice to prepare a paste. This is used in the art of temporary tattooing the skin and has been used to adorn young women's bodies as part of social and holiday celebrations since the late Bronze Age. The henna plant is native to North Africa, the Middle, and Southern Asia and Northern Australasia, in semi-arid zones and tropical areas.

When the paste is applied to skin, it is left for a few hours, leaving a dark maroon stain on the skin. This normally fades away in two to three weeks. Henna paste may be mixed with natural oils such as eucalyptus or clove oil. If you are allergic to either of these, henna tattooing should be avoided. Essential oils with high levels of monoterpene alcohols, such as tea tree, cajeput, or lavender, will improve skin stain characteristics. Other essential oils are also used but can be irritating and are best avoided on sensitive skin. Therefore, it is important to know the origin and contents of the paste being used.

Painting henna designs on the body is a long-established practice in some parts of the world. However in recent years, street stalls offering henna 'tattoos' have become big business in sun resorts all over the world. Most parlours offering this service use pure henna, which very rarely causes skin reactions. However street vendors may add a chemical called PPD (para-phenylene diamine), in order to make the tattoos appear darker. Henna containing PPD can cause contact dermatitis in some people, according to scientists at the Dermatological Centre in Buxtehude, Germany. PPD is banned in the USA where the sale, distribution and use can attract penalties. Moves are afoot to ban it in Europe. Reactions are rarely manifested until several days later, so the henna artists may not know the extent of the problem they are causing. Reassurance from the artist that they are using pure henna cannot always be trusted.

It is possible that the reaction from the tattoo will last for several months. Henna tattoos are supposed to last for no more than two weeks. Worse still, PPD

can cause severe allergic reactions, with blistering, intense itching, permanent scarring, keloid and hypopigmentation. Rarely hypertrichosis has been reported (dark hairs growing in the painted areas). The initial acute reaction is often confused with infection (impetigo) and antibiotics are often prescribed with good intention. Skin swabs do not help the diagnosis. Initial treatment consists of strong topical steroid creams, antihistamines and silicone gels. Basically treat it like a contact dermatitis or burn. Affected areas should be protected from sunlight. Diagnosis is based on history and dermographic rash in the pattern of the artwork.

Our patient was treated with topical steroids, emollients and oral cetirizine. She made a good recovery and graciously consented to her rash being photographed for educational purposes. All of us working in Travel Medicine should be aware of the dangers of black henna and advise our clients to avoid them.

Aideen O'Callaghan

Practice Nurse, Glencairn Medical Centre, Dublin



Henna tattoo

References:

1. Deborah Condon of the Irish health website www.irishhealth.com
2. Ip, Natasha, Hoddes, J : Lancet, Volume 383, No. 9926, p1436, 19 April 2014
3. El Habr C, Mégarbané H J Dermatol Case Rep. 2015 Jun 30;9(2):36-8.

GLOBAL ROUND-UP

EBOLA VIRUS: 17 Dec 2015 - A total of 165 contacts of the recent family cluster of Ebola virus disease (EVD) in Liberia have now completed the mandatory 21-day monitoring. If no further cases are reported, transmission of Ebola virus linked to this cluster will end on 14 January 2016, which will be 42 days after the most recent case had a second negative test for Ebola virus. This recent cluster of EVD is now thought to be the result of re-emergence of persisting virus in a previously infected individual. *Source: <http://www.who.int/ebola>*

17 Dec 2015 - Human-to-human transmission of Ebola virus linked to the primary outbreak of EVD in Guinea will end on 28 December 2015. That date will be 42 days after the most recent case, reported on 29 October 2015, received a second consecutive negative test for Ebola virus. *Source: <http://www.who.int/ebola>*

POLIOVIRUS: Laos: A further two cases of vaccine-derived poliovirus type 1 (VDPV1) have been reported to WHO by the Laos National IHR Focal Point. Both cases have been identified in Xaisomboun province in the north of the country, near the capital Vientiane. The first case is a 7 month-old child in Hom district, with onset of paralysis on 3 October 2015. The second case is a 14-year-old male in Anouvong district, with onset of paralysis on 28 October 2015. The total number of cases in Laos is now 7. Six rounds with trivalent OPV vaccine have been planned from October 2015, to March 2016, (4 sub-national and 2 national) with ~ 8.6 million doses to be administered to children younger than 15 years. *Source: <http://www.who.int>*

DENGUE FEVER: Further cases of dengue fever have been reported in Hawaii. As of 7 December 2016, a total of 139 confirmed cases have been recorded. Of those, 122 are local residents and 17 are visitors to the islands. A CDC expert on vector-borne diseases reported that the outbreak could go on for several months more and the number of possible cases was unpredictable. *Source: ProMED*

Dengue fever has been reported from Ecuador. As of 20 November 2015, a total of 41 984 cases have been recorded; of those, 1274 have been confirmed as dengue virus infection. *Source: ProMED*

Dengue fever is an ongoing risk in Colombia. As of 20 November 2015, 82 308 cases have been reported. *Source: ProMED*

Further cases of suspected dengue fever continue to be reported from Sudan. The outbreak of suspected cases was first reported on 29 August 2015, and as of 4 December, a total of 557 cases including 130 deaths has been recorded. Initially the outbreak was confined to Darfur, however, suspected cases have now been identified in the states of Kassala and Kordofan. Between 29 August-4 December 2015, 27 states of Darfur reported a total of 512 suspected cases and 125 deaths. Between 17 October- 4 December 2015, six localities of Kordofan: Abyei, Keilak (West Kordofan), Reif Ashargi, Kadugli, Habila (South Kordofan) and Shiekan (North Kordofan), reported a total of 40 suspected cases and 4 fatalities. In Kassala state, five suspected cases and one death were reported in the state capital Kassala town between 23-26 November 2015.

Investigation into the outbreak is ongoing and plans are being made by WHO and the Ministry of Health to deploy laboratory facilities and experts from the Institut Pasteur, Dakar, to support field diagnosis and strengthen the capacity of the central public health laboratory in Khartoum. *Source: <http://reliefweb.int>*

Dengue fever is an ongoing risk in Costa Rica. As of 20 November 2015, a total of 11 674 probable cases have been recorded thus far in 2015. *Source: ProMED*

Dengue fever is an ongoing risk in El Salvador. As of 20 November 2015, a total of 46 059 probable cases have been recorded thus far in 2015. Of those, 9490 have been confirmed as dengue virus infections. *Source: ProMED*

AVIAN INFLUENZA: CHINA: The Macau Department of Health announced on 11 December 2015, 6 new cases of human infection with H7N9 avian influenza. The cases were located in the following provinces of China: Anhui (1), Hunan (3), Guangdong (1) and Zhejiang (1). The cases are male (3), female (3), age range 1-74 years; 2 cases are reported to be in a serious condition with 4 in a stable condition. Three cases gave a definite history of contact with live poultry, farmed poultry, or live poultry markets. *Source: ProMED*

MEASLES: The long-running measles outbreak in the Democratic Republic of Congo's southeast province of Katanga is not yet under control. By the end of November 2015, more than 47 000 suspected cases and 500 measles related deaths were recorded. The outbreak has spread rapidly and the number of Health Zones affected has increased from two at the end of 2014, to 24 by October 2015.

UNICEF and the World Health Organisation are collaborating to contain the epidemic, in partnership with Congolese Ministry of Public Health and several non-governmental organisations. *Source: www.unicef.org*

Travel Medicine Conference Calendar

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Date: 14 – 26 February 2016, to Uganda,

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Location: Ardboyne Hotel, Navan, Co. Meath
Time: 9:00 am – 1:00 pm
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THE 11TH ASIA PACIFIC TRAVEL HEALTH CONFERENCE 2016

Themed “Wilderness and mountain medicine: Travel medicine where it happens”, APTHC 2016 will be at Yak & Yeti Hotel.
Web: [www.http://apthc2016.com/](http://apthc2016.com/)

DATE: 2 - 5 MARCH 2016

8TH TROPICAL MEDICINE EXCURSION

Tanzania, East Africa. In collaboration with various teaching hospitals in Tanzania and Kay Schaefer (MD, PhD, MSc, DTM&H), Cologne, Germany. 13 days round-trip excursion. Includes individual on-site bedside teaching, laboratory manuals (hands-on microscopy on parasites in the blood, stool, urine and skin), field excursions and lectures. Accreditation: 60 CME contact hours by the Medical Association, Düsseldorf, Germany. Official language: English. www.tropmedex.com

Date: 13 – 25 March 2016, to Tan-

NATIONAL CONFERENCE ON WILDERNESS MEDICINE
Big Island of Hawaii
Web: www.mtnreg.com/hawaii2016

Date: 30 March - 3 April 2016

E-mail: info@ameetingbydesign.com

6TH NORTHERN EUROPEAN CONFERENCE ON TRAVEL MEDICINE

Location: Queen Elizabeth II Centre, London.
For further information, please contact: nectm6@in-conference.org.uk or: www.nectm.com

Date: 1 - 4 June, 2016

7TH REGIONAL CONFERENCE OF THE INTERNATIONAL SOCIETY OF TRAVEL MEDICINE

Port Elizabeth, South Africa
Web: www.istm.org

Date: 28 September - 1 October 2016

4TH TROPICAL MEDICINE EXCURSION

Ghana, West Africa. In collaboration with various teaching hospitals in Ghana and Kay Schaefer (MD, PhD, MSc, DTM&H), Cologne, Germany. 11 days round-trip excursion. Includes individual on-site bedside teaching, laboratory manuals (hands-on microscopy on parasites in the blood, stool, urine and skin), field excursions and lectures. Accreditation: 60 CME contact hours by the Medical Association, Düsseldorf, Germany. Official language: English. www.tropmedex.com

Date: 30 November – 10 December 2016, to

Items for the newsletter can be forwarded to:

drconormaguire@gmail.com

or

annehredmond@eircom.net

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