



Report from the Asian-Pacific Travel Medicine (APTM) Meeting

Karl Neumann, MD, FAAP

Bangkok, Thailand. Travel health professionals often say that there is more to keeping travelers healthy than “giving shots and prescribing pills.” But, in fact, too often the “more” in that message does not come through loud and clear to travelers. “More” needs to be done to emphasize that disseminating information is the cornerstone of travel medicine and that immunizations and medications supplement that information. This was the consensus of several well-known travel medicine specialists who spoke at the APTM in November. The meeting attracted almost 600 individuals from several dozen countries. Many of the speakers were ISTM members.

In many parts of the world, both developed and developing, much of travel medicine is practiced by health care professionals not well versed in the field and who are unaffiliated with local or international travel medicine groups. Most of these practitioners limit their services to providing immunizations and medications – and not always correctly. But even travelers who seek out professionals in the field do not always walk away with neces-

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Are You Ready for Vancouver?

On behalf of the Scientific Program Committee it is my great pleasure to welcome you to attend the 10th Conference of the International Society of Travel Medicine in beautiful British Columbia, Canada May 20-24th 2007.

This meeting represents an important milestone for our society and to celebrate this landmark our Committee has worked diligently to put together a fantastic array of exciting and topical plenaries, symposia, workshops and debates covering all aspects of travel and migration medicine.



These include:

- Medicine at the Extremes (altitude, diving and polar travel)
- Epidemic and PANDEMIC VIRAL DISEASES
- Migration and the Big 3 (HIV, Malaria and TB)
- Vaccines: closer than the horizon (flavivirus, malaria and travellers diarrhea vaccines)
- Women and Adventure Travel
- Travel, Blood and Sex
- Visiting Friends and Relatives
- Risk and Reduction
- Rabies Update
- Arthropod Borne Disease – the insects view
- Artemisinins and MALARIA
- When Nature BITES BACK: shark, primate and bear attacks

Furthermore, due to a great response from our membership, we have also compiled their abstract submissions into a fabulous selection of high quality oral and poster presentations featuring the latest clinical studies and treatment trials related to travel, tropical and migration medicine.

Some highlights include:

- Artemether/Lumefantrine in the Treatment of Acute, Uncomplicated P. Falciparum Malaria in Non-Immune Travellers: An Efficacy, Safety and Pharmacokinetic Study.
- Malaria from Latin America: Declining Local Transmission and Risk of Travel Associated Malaria. Are Current Guidelines

Appropriate?

- Safety and Tolerability of the Japanese Encephalitis Vaccine IC51. A Double-Blind, Randomized, Placebo Controlled Phase 3 Study.

• A Randomized Placebo-Con-

trolled Phase Ia Malaria Vaccine Trial of Two Virosome-Formulated Synthetic Peptides (AMA-1 and CSP) in Healthy Adult Caucasian Volunteers.

- Children Travellers Morbidity – Prospective Controlled Cohort Study.
- Visiting Friends and Relatives - An Asian Airport Survey.
- Risks of Hepatitis B for Travelers. Is Vaccination for All Travelers Really Necessary?
- The Impact of International Travel on the Spread of Poliomyelitis 2003-2006.
- Are Travelers with Children Better Prepared? Pre-Travel Health Preparation among U.S Residents Traveling to India.
- Clinical Features of Patients with Severe Altitude Illness in Nepal.
- Mortality of Travelers from Japan, Europe, Australia and U.S.A. in Nepal from 1996 to 2005.
- A Review of Cutaneous Leishmaniasis in the UK Armed Forces (2005-2006).
- US Citizen Pediatric and Young Adult Deaths Abroad.

On behalf of the scientific chairs and our entire Committee, we wish to express our sincere thanks to the membership for their fantastic support and essential contributions to the scientific content of this meeting. We look forward to seeing you in Vancouver!

Warm wishes,

Kevin C. Kain
Chair, Scientific Committee

Herwig Kollaritsch
Co-Chair, Scientific Committee

Thinking Outside the Syringe: Opportunities for Travel Health Care Practitioners

Networking with other specialists in the community



Gary Podolsky, MD

Travel medicine practitioners function within their own well-defined niche within a community. And they coexist with numerous other health care professionals who also have their own well defined niches. And each specialty is becoming more sophisticated in the services they offer, making it a more complex operation.

As practitioners become more focused on their own areas of expertise, they often lose sight of the broader picture. As a result they may fail to see the many possibilities that exist for complementary benefits for their clients/patients and for themselves by understanding the objectives, strengths and needs of practitioners in other subspecialties, and how communicating and working together can be mutually beneficial.

For example, travel clinics are ideal for assessing last minute travelers needing immediate immunizations and medications. Many clinics also perform physical assessments of patients (pre-trip physicals and assessment of medical problems just prior to travel). Why not extend such services to other patient populations?

Helping surgeons. In some communities surgeons need immediate preoperative physical exams on their patients as operating room time suddenly becomes available. Travel clinic physicians may have flexibility in their schedule to accept such cases. This can only help increase access of their other services and leads to a high level of both patient and referring physician satisfaction. "When we realized

that many pre-op patients were desperately seeking last minute physicals, we remembered that years earlier we observed that last minute travellers had the same issue, so we started our travel clinic. We began offering immediate preoperative physicals and found the response overwhelmingly positive. This has helped us in our slow seasons," says a manager of a large multi-specialty clinic.

College and university admission requirements. Many institutions now require pre-matriculation immunizations. Requirements may include tetanus-diphtheria, hepatitis B and meningitis vaccines, for example. Anticipating acute increases in demand (currently meningitis vaccine, for example) can help clinic clerks maintain a proper reservoir of stock and avoid shortages. Clinics may anticipate the need for appointments near the start of school terms and allow for students to have quick access.

Influenza immunization clinic. The annual flu vaccination may serve as a "gateway" vaccine allowing patient to consider other vaccines - provided the immunization is delivered professionally and explained correctly. Also many medical clinics are moving into the business setting to administer vaccines and other services to employees. According to another clinic manager, "Flushots@work became the motto of our at-work immunization program. We found that in the workplace setting people were more approachable to getting a vaccine. This suggested that immunizations were more tolerated at a familiar site than in our institution. We decided that it was important to go onsite to facilitate the acceptance of immunization with select groups."

Educating business organizations about immunizations. It recently came to the attention of a municipal hydroelectric company that many of its servicemen performing maintenance work on downtown sewers were encountering needles and syringes discarded by IV drug users. These workers were mostly involved with electric wires and their job description did not include hazardous waste exposure. The company decided to initiate a hepatitis B immunization program to deal with this unanticipated problem.

Aestheticians (cosmetologists) and body art workers are becoming aware of the need for hepatitis B immunizations because of the hazards from sharps in cosmetic settings. Similarly many restaurants are now immunizing their employees with hepatitis A vaccine to protect the employees and patrons - and also their business's reputation.

We found that by attending the trade shows of the aesthetic community (beauty salons, tattoo clinics) and the food and hospitality industry, we could inform more people who were still part of our target demographics for immunization but had been left out by traditional public health initiatives.

Reminding patients of other health services.

Many young women traveling overseas will not have access to routine medical care and may miss important regular health examinations (pap tests, for example). Most travel clinics will be unable to accommodate them. However in many communities there are easily accessible facilities where women can receive such tests. Displaying a poster in the travel clinic reminding women travelers of such services will be helpful. Similarly, travel clinics can inform family practitioners and obstetricians/gynecologists that they will administer Gardasil, the new human papilloma virus vaccine. Many OBs/GYNs and GPs do not stock such vaccines. But travel clinics have the expertise to do it, even though this is not a "travel vaccine". Ditto for Zostavax, the vaccine against herpes zoster.

Here is an example of a poster we use to direct women travellers to services outside our travel clinic:

We recognize that many of you will be away from Canada for more than one year. While



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traveling you may not have the advantage of seeing a regular family physician. This is worrisome as cervical cancer screening with a pap test is important. By leaving the country for a long time you may delay screening. We encourage you to visit your family doctor before you go to see if you need a pap test. Our clinic does not provide this service but many do. A pap test can be done at your doctor's office, community health clinic, or nursing station in your area. We have compiled a list of such facilities for you.

If you need a Family Doctor, call... for a referral

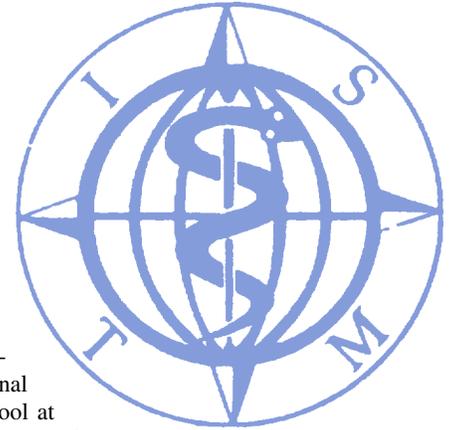
In conclusion, these are only a few examples of how travel medicine clinics can find extra work in their area without changing the focus of their practice. As centers specializing in service they may be able to integrate new ideas into a traditional immunization practice that will also keep their clients healthy.

Society News

Research Committee report: poster accepted for ISTM10

We are pleased to announce that the Clinical Trials group of the Research Committee has had its first study's results accepted as a poster session at ISTM10. The poster is titled "European and North American Travelers' Preferences in the Treatment and Prevention of Diarrhea" by N Melgarejo, T Jelinek, AE McCarthy, CD Ericsson and the International Society of Travel Medicine Clinical Research Group. Dr. Melgarejo is a resident in internal medicine at the University of Texas Medical School at Houston. His primary interests are in infectious diseases and international medicine. Please drop by and support his budding career.

This is a reminder that the clinical research group can facilitate meaningful research across multiple travel medicine clinics. If any member has ideas for a research project they should contact either Thomas Jelinek (jelinek@bctropen.de) or Charlie Ericsson (charles.d.ericsson@uth.tmc.edu).



View from the Mountain

Dear Friends,

It is incredibly hard to believe that we are only a few short weeks away from the opening of CISTM10! We hope you have already made your plans to attend – if not what are you waiting for??? CISTM10 promises to be a great meeting and you certainly will not want to miss out on all the new information as well as meeting friends, old and new, from around the world.

Membership renewal. It is that time of year again and just a reminder that if your payment is not received by March 31 – all of your member benefits, including clinic listings, list serve participation as well as the journal will be suspended until your fees are paid. The easiest and quickest way to accomplish this is through online renewal. Please let us know if you need a replacement username and password to log onto the system.

Membership payments. We need your help in this area. We know that many of our members' dues are paid by their place of employment. Unfortunately, there are times we receive checks with no clue as to who the payment should be applied to. We then spend, at times, a few hours, trying to track down the member's name that goes with this payment. There have been a few instances where we were never able to figure it out and the check had to be returned. If your institution or employer is paying for your membership fee, please ask them to return the membership form or at the very least, put your name somewhere on the check. This way it saves us a great deal of time and also ensures that you receive the proper credit for your payment.

Clinic listings on the web. This is not an automatic process. Joining the ISTM or updating your membership information does not automatically transfer over to the clinic listing. You will need to enter this data separately by logging onto member services and choose 'manage clinic listings' from the 'member management' heading. New listings require a very short form to be completed and once submitted take a maximum of 48 hours to be posted. Updates to your current listing can also be completed from this same section.

ISTM Certificate of Knowledge Examination. The deadline for registering to sit for the is April 16, 2007. If you are planning to take the exam this year, please be sure to get your application into our office prior to the deadline – applications received after that date will not be accepted. Extensions to this deadline will not be given! Please remember that we cannot accept faxed versions of the exam application as the required two pictures are not clear when they are faxed.

We look forward to seeing many of you in Vancouver. Please be sure to stop and say hello. It is always a treat to spend a little time catching up on the past 2 years. As we say here in the South of the U.S., it reminds us of 'old home week.'

Until next time, remember that "if there is any kindness I can show, or any good thing I can do to any fellow being, let me do it now, and not deter or neglect it, as I shall not pass this way again" (William Penn).

Take care,

Brenda and Brooke

—“Report from the Asian-Pacific Travel Medicine (APT) Meeting,” cont. from p. 1 —



sary information, either because it was not given or was given in a way that the traveler did not fully comprehend. For example, surveys continue to show that travelers do not use malaria medication correctly, do not follow food and water precautions and, when they come home ill, fail to tell their physicians of recent trips. Nor do most physicians ask patients, “Did you travel recently?” When the answer is “no,” this process takes less than five seconds. When the answer is “yes,” it can cut in half the length of the workup and may be lifesaving.

Here are some of the recommendations heard in an open forum on improving the quality and delivery of travel medicine health care:

- More time spent in conversation with the traveler.
- Handouts. These have to be simple, to the point, and relatively short. Most travelers will not read long, detailed articles. Even fewer travelers buy books on travelers’ health.
- Label handouts “Read at Your Destination” and “Read on Returning Home.”
- Phone calls to travelers on their return home.
- Mailings to patients several weeks after the initial visit addressed to their overseas address for long-term travelers and home address for short-term travelers.
- Stickers to attach to passports and immunizations cards.
- More lectures and publications for primary health care practitioners on travel medicine.
- Travel health-related articles for magazines found aboard airlines. (Most such maga-

zines now have articles on the prevention of deep vein thrombosis.)

- Posters for emergency rooms and doctors’ offices to remind both patients and staff to discuss recent travel.

The facts that the conference took place in Southeast Asia and that more than half of the faculty resides in this part of the world added relevancy to the meeting. This is the “epicenter” of SARS and H5N1. One speaker related how 1.5 million poultry were destroyed in a matter of three days in Hong Kong and how this possibly prevented a worldwide pandemic. Another speaker discussed the difficulties in producing effective vaccines and medications to counteract the H5N1 virus. Present research, by necessity, targets the virus now circulating. Two factors that make H5N1 so ominous are its abilities to mutate frequently and to combine with human virus(es) during co-infection, creating a new virus that is quite different from the virus now in circulation.

Fortunately, while H5N1 possesses most of the prerequisites to start a major pandemic, it still lacks the ability to spread efficiently among humans and to sustain that ability.

Here is some other interesting information presented by speakers. (These opinions are those of the speakers, recognized experts in travel medicine.)

“No diversion” clause/Airline tickets. While chances are that you are familiar with the “Do Not Resuscitate” clauses for terminally ill patients in hospitals, you may not yet have heard of “No Diversion” clauses for critically ill airline passengers. Apparently,

many such passengers/patients travel, usually to their country of origin to spend their final days there, and to die and be buried there. Such passengers are more likely to have serious medical events during flight, events that ordinarily dictate diversion of the aircraft for an immediate landing at an airport closer than the destination. Diversions add an element of risk, albeit a minor one, to the flight, are inconvenient to the other passengers aboard (delays can amount to six hours or more), and are extremely expensive for the airline. It may require dumping of fuel, landing costs, and delays. Costs are usually in the tens of thousands of dollars. At least one large Asian airline, when the airline is aware of such cases, requires that the patient or the patient’s family sign a document stating that under no circumstances will the aircraft be diverted for a medical reason relating to this passenger.

Laos/Travel medicine. Laos is attracting an increasing number of visitors, with many venturing into remote parts of the country, exposing themselves to food-borne diseases rarely seen in the developed world. In the past, home cooking was the typical source of outbreaks, and outbreaks were small in scope. Today more people eat outside the home and 80% of such diseases occur from exposure outside the home. Raw or undercooked foods are popular and there have been large increases in the production of aquaculture foods. Sanitation, which has always been problematic, has not kept up with the expansion of the food industry, especially aquaculture food production. Laos is a high transmission area for trematode and nematode infections, in large part from eating raw or undercooked seafood. Diseases being reported with increased frequency in Laos and the symptoms associated with them include:

- Opisthorchiasis. From ingestion of fresh water fish. Causes acute liver disease and may lead to liver cancer.
- Paragonimosis. From ingestion of crabs. Causes chronic coughs, bloody sputum, and secondary bacterial pneumonias.
- Angiostrongyloidosis and Gnathostomosis. From ingestion of crustacean, fishes, frogs, snakes, and snails. Causes eosinophilic meningitis.

Traffic-related mishaps account for the majority of morbidity and mortality among travelers in Laos, as in most developing countries. Traffic is “unruled” and increasing rapidly, and

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safety measures are not keeping up. Especially at risk in Laos are motorbike users and pedestrians. (WHO estimates that worldwide 1.2 million people die and 50 million are injured in traffic-related accidents.)

Dengue fever. Dengue may be the most important emerging disease among travelers to Southeast Asia and has become the most common arboviral disease in the tropics and subtropics, areas increasingly popular with tourists. In some studies, dengue is the second most common cause of hospitalization (after malaria) among travelers returning from the tropics. In another recent report the disease was the most frequent cause of fever in travelers returning from Asia.

Developing countries: Arrival of large number of refugees, immigrants, and migrants. Health care issues and other problems caused by the presence of large numbers of refugees, migrants, and immigrants from poorer nations are not limited to the so-called wealthy nations of the developed world. In Thailand, for example, relative economic and social stability has become a significant ‘pull’ factor, attracting many individuals from nearby countries. This phenomenon tends to occur anytime one country raises its standard of living more rapidly than that of its neighbors. However, by most international standards, Thailand remains a developing country with considerable illiteracy, poverty, high rates of many diseases and a high infant mortality rate, for example. Presently more than 1.5 million “irregular” visitors (the exact number is unknown) from poorer neighboring countries reside in Thailand. More than 80% of the “irregulars” are believed to originate from Myanmar. These visitors bring new health-related issues, stretch resources and cause friction, especially in a country barely able to cope with its own health-related problems. Thailand’s health system is one of the most advanced in the region and is implemented through a network of primary health care centers, community and general hospitals across 795 districts in Thailand’s 63 provinces.

Rabies/Routine pre-exposure vaccinations/School children/Thailand. Rabies remains a significant public health problem in developing countries where post-exposure prophylaxis is costly and canine rabies is endemic. Children are the most vulnerable population and represent the majority of rabies deaths worldwide. In school-aged children in Thailand, a pre-exposure immunization regimen of three intradermal doses of purified chick embryo cell vaccine led to adequate immune responses. After primary vaccination all subjects developed rabies virus neutralizing antibodies and demonstrated a rapid increase in RVNA titer after two stimulated post-exposure booster immunizations one year after the primary vaccination series. The authors conclude that implementation of pre-exposure immunization could save the lives of many children in rabies-endemic areas.

Karl is the editor of this Newsletter. In addition, he writes frequently about travel medicine for both professionals and the public.



A Bath to Remember

While the hotel for the Asia Pacific Travel Medicine conference was quite nice if not spectacular, the bathroom was a dream, a surreal one.

Behind the rather long tub, instead of a wall, was a window the length of the tub and extending to the ceiling. The view? Typical Bangkok, but not one likely to appear in the city’s travel brochures. Extending in both directions as far as the eye could see was a track of land only about 100 yards or so wide. This track contained four parallel roads with 27 lanes of traffic on two levels, two railroad tracks, and, every ten yards or so, long abandoned, weed and tree overgrown concrete pillars, probably the framework for two additional elevated structures. Beyond this, nondescript houses.

After sitting in the tub taking in this absurd but fascinating panorama, I looked for the soap, fully expecting to leave the bath to fetch it, having once again forgotten to check if it was by the tub. Wrong. The soap was easily reachable, next to a TV remote control unit, probably left there by an absentminded housekeeper, I thought. Wrong again. Near the ceiling, over one end of the tub was dangling a TV set, easily viewed from the tub. My first impression was one of imminent electrocution should the TV or remote join me in the tub. But on second thought, the hotel would not be promoting guests’ demises. Likely the remote was harmless, and the TV well bolted to the wall/ceiling. Inexplicably, this TV was far superior to the rather poor one viewable from the bed. It actually required a bath to watch CNN.

And there is more, making this my bath of all baths. I could laze indefinitely without moving, simultaneously watching TV and monumental traffic jams. With my toes I could negotiate the large faucet lever to turn the water on and off, move the lever sideways to choose water temperature, and open the drain, a 4 to 5 inch disk with toe/finger impressions. This hotel is aptly named, The Miracle Grand.

Travel Medicine: Brazilian style



Dr. Marco Foltran

Like so many of us in travel medicine, I became involved in our specialty more or less by accident. I trained in internal medicine and aero-medical transportation and became certified in emergency procedures such as Advanced Cardiac Life Support, Basic Trauma Life Support, and Pediatric Advanced Life Support.

In 1997, after I finished my medical training in Curitiba in the southern part of Brazil, I moved to Porto Seguro, a city in Bahia State in the Northeast. Porto Seguro is a beautiful place with about 80,000 residents, idyllic beaches, wonderful weather, and 1.5 million visitors per year. In the three years I was there I worked for an emergency health care system answering house calls, including many from hotels to see travelers. All together, I saw about 5,000 travelers. Most of them had minor ailments such as traveler's diarrhea, external ear infections, sore throats, allergies, and minor trauma. I also treated problems related to scuba diving, air travel, marine accidents, and exposures to new climatic conditions, sun and heat, for example. And, unfortunately, there were the occasional serious problems.

I came to realize that travelers are a unique group of people, and what an appealing field travel medicine is – without knowing that travel medicine existed. Not only did I help to restore their health, but I also helped them to accomplish their goal for which they were in Porto Seguro, to relax and to enjoy themselves. Wellness is the key. The obvious aim of the sick or injured traveler is to get back into the action as soon as possible. Sometimes they want miracles. It is our role to make it possible, with minimum limitations on their planned activities and in the fastest way. No one wants to ruin his or her trip with health

problems; no one wants to miss the opportunity to see the sunset in Jericoacoara in Ceará State (a trip that I personally recommend) because of diarrhea. The aim of travel medicine is to keep people healthy during their trip, whether it is through pre-travel advice or visit to a physician during the trip.

Seeing so many travelers made me realize how demanding and difficult this field can be. You need to know so many different areas of medicine, be up to date on health-related conditions all over the world, and have fluency in other languages. The knowledge of the traveler's needs is challenging but especially gratifying.

I did travel medicine for five years before I became aware of the existence of the International Society of Travel Medicine and without any contact with colleagues in the field. Now I have read several travel medicine books, receive the Promed mail, and am involved with a couple of listservs. I am proud to be part of

the GeoSentinel and the ISTM Host Country Committee. Moreover, I am working on some papers and I hope that in the next few months to send them to the Journal of Travel Medicine for publication.

Making so many hotel calls gave me the knowledge and skills to start giving pre-travel advice - with confidence. I know, from the other side, what really happens during international travel.

Since 2000, I live in Fortaleza in Ceará, also in the northeastern part of Brazil. It is a large city with 3 million inhabitants and 2 million visitors per year, a paradise for kite and windsurfers, those who love tropical climates all year round, and warm and friendly people.

Currently I have my own practice for pre-travel advice. I still work on emergency calls at hotels. I do consultations for colleagues and

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An Invitation to Nurses attending CISTM10 in Vancouver!

The Practice and Nursing Issues Committee (PNI) invites all nurses attending the conference to the *Nursing Welcome Reception* on *Sunday May 20th*.

- Meet and greet colleagues from around the world
- Hear about some conference highlights
- Learn what nurses are doing to formalize practice
- Enjoy Refreshments

DATE: Sunday May 20th (prior to CISTM10 Opening Ceremony)

TIME: 15:00-16:30 (3:00 pm-4:30 pm)

WHERE: Fairmont Hotel Waterfront Ballroom (next to the meeting conference center; directions will be provided in registration bags on-site and posted at the registration area)

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for hospitals, and I lecture on travelers’ health-related subjects at universities that teach tourism. I am part of an organization that offers 24-hour emergency service all over the city with English-speaking doctors, an ICU ambulance service, laboratory, mobile ultrasound, and affiliations with major hospitals (with international accreditation). We accept all travel insurances and the fee for hotel calls is reasonable (about USD 100). The main way we publicize our services is by word-of-mouth among the tourism trade, publicity releases, and with some articles in non-medical journals and magazines.

To examine a patient, prescribe and treat in another language can be challenging, in part

due to different cultural values. But in the past nine years of working with travelers, I have learned that respect for their cultures, showing them kindness, and understanding that their special needs are as important as prescribing the right medicine.

About five years ago I took an MBA degree in Health Systems Management. Last year I attended the travel medicine course at the Royal College of Physicians and Surgeons in Glasgow, where I had the opportunity to be with the HPS travel medicine team and exchange experiences with such people as Dr Eric Walker, Mrs. Lorna Boyne, Mrs. Fiona Genasi and many others. I speak English, French, Italian, Spanish and Portuguese and I can ask medical

questions and prescribe in 11 different languages (Finnish, Hungarian, German, Polish, Czech, and Swedish). This is a big and pleasant surprise to my foreign patients. I am sure that when one is sick it is NOT a good time to try learning a foreign language.

I am married; my wife’s name is Seline and I have two children, Barbara (12) and Massimo (3). I used to windsurf, but I am quite sedentary right now. My favorite sport is American football (not soccer – unbelievable, ha?). I enjoy reading and traveling, and especially to talk to foreigners which I do almost every day. This too is “traveling” to me, so I really have fun with my work.

One of the many things I like about travel medicine is that there are many humorous and memorable incidences. Here are some that come to mind:

- A honeymoon couple from Argentina was very ill with classical travelers’ diarrhea. Both were very pale, without any strength to get up from the bed and even unable to open the door for me. After we started treatment with IV ringer lactate, antibiotics, etc. they began to feel better, and their mood improved. So they asked me to take a picture of them lying in bed, both hooked up to IV infusions. They said they would place the picture in their “honeymoon album”, because the priest had said during their wedding ceremony that they were a couple “... for richer or poorer, in sickness and in health ...” So the picture of them drinking coconut water on the sunny beach will be next to the one with the IV in bed.
- A young Dutch lady who called me late in the night with a “yellow color in her skin.” I went to the hotel thinking about several possibilities, leptospirosis, hepatitis, and such. But when I got there the yellow spots were only on her hands. The history and clinical examination were totally normal. A very strange case. But then I noticed some old books on the side of her bed. I asked her to wash her hands. Bingo! The yellow color came from the old books. She was so ashamed, but she laughed and was very happy there was no illness to worry about.
- A Canadian young man, two days before the end of his vacation and after six days of traveler’s diarrhea, called me at the hotel. After I treated him, I asked him what he thought about Brazil? He said “Nice toilets!” It was a remarkable way to describe a vacation time.
- I was in a hotel room suturing a laceration in an 8-year-old boy from the USA. His father was watching. Suddenly I heard a big noise and the father just collapsed on the ground when he saw the blood. The result: four sutures for the boy and six for his father.
- This one is incredible. A Hungarian traveler was in the back seat of a taxi, after buying a magnificent dagger made of a serrated bony spine from a stingray. He was holding it in a plastic bag under his elbow. The taxi stopped very suddenly to avoid a crash with a bus. The bony spines pierced the man’s elbow and caused a 4-centimeter laceration. He arrived in the lobby with the dagger hanging from his elbow, dripping blood. No one at the hotel could understand what or how this happened. The traveler spoke only Hungarian. The manager of the hotel asked if he was assaulted and if he should call the police. The only thing the traveler was saying was “bus accident!” We removed the dagger without any complications and the traveler was fine.
- In one of my very first medical calls to a traveler I saw a pregnant (5 weeks) young lady from Chile with travelers’ diarrhea. I speak Portuguese; she spoke Spanish. Portuguese and Spanish are similar, but not identical, and at the time I didn’t speak Spanish as well as I do today. She told me about her gastrointestinal complaints and that she was pregnant, all in Spanish. The word for pregnant in Spanish is “embarazada”. This word in Portuguese (similarly to English) means “to feel uncomfortable because of shame” or “embarrassed”. The dialog went something like this: “One more thing: I am embarrassed (embarazada), doctor,” she told me. “There is no reason to be embarrassed, this is something simple and is quite common,” I told her. “No, doctor, I am embarrassed,” she insisted. “No problem, my dear, there is no reason to be ashamed or feel uneasy. Travelers’ diarrhea is not a big deal, you will be fine in a couple of days,” I replied. “No, no, no, doctor, I am REALLY embarrassed!” she laughed. I nodded and said, “OK, try to explain it to me...” Then she put a blouse under her T-shirt to indicate an extended abdomen, and pointed.

Well, after that I was feeling “awfully uncomfortable” because of shame, and realized that I should learn more languages than Portuguese and English...

The Way it Was

Advice for Travelers to the Tropics, 1880s

I would especially urge on the traveller, if he is visiting the tropics, the absolute necessity of extreme moderation in the use of alcohol. Indeed, it is better to go to the extreme of abstaining altogether, than to go to excess in this matter, which is remorselessly punished by nature.

At the same time, alcohol is a valuable medicine and should not be excluded from the traveller's repertory. For an expedition not likely to last more than a year, the following amount will be found sufficient: Two dozen of good champagne, three bottles of sherry, four bottles of brandy, and four of whisky. Claret, burgundy, and port travel badly, although as tonics and blood-making wines they are among the best.

Except under extraordinary circumstances, such as accidents or deadly faintness, alcohol should never be taken in the day-time, but reserved for the evening, and if the want of it then felt, it should preferably be taken in the form of champagne, or brandy or whisky and water.

The practice of so many German travellers of taking small quantities of neat brandy or other spirit in Africa during the day is most deleterious, and if pursued for any length of time will inevitably prove fatal.

H.H. Johnston, *Hints on Outfit*, 1889. Compiled by Simon Brett, *Take a Spare Truss*, Elm Books, London 1983.

NewsShare

the Newsletter of the International Society of Travel Medicine

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