



Caring for Travelers While They are Overseas

Will Telemedicine Play a Role?

Karl Neumann MD, FAAP

Travel medicine and telemedicine have both come of age, and they have found each other. The two are now in the courting stage, getting to know each other better, considering each other's strengths and weaknesses. But both realize that they were made for each other; that, sooner or later, marriage is inevitable; and that the couple(ing) will mature in one form or another, and become a meaningful and on-going relationship, beneficial for all involved.

This is the general sentiment of the sixty-five ISTM members who responded to a short questionnaire placed on the ISTM ListServ, asking them:

- Do you as a travel medicine professional have a responsibility to provide services to your clients while they travel overseas?
- What kind of services do you provide?
- Do you see a future for telemedicine in travel medicine?

Fortunately, many respondents passed up the chance of merely checking "yes" and "no" boxes on the questionnaire, and instead spent time writing well thought out paragraphs. Responses came from all over the world.

Surprisingly, the respondents were very much divided on the responsibility that travel health professionals have for their clients once they leave their offices. Also, travel medicine practitioners have widely different conceptions of the term "telemedicine." To some this means telephone and email communication with their clients overseas, while others think that it should include sophisticated monitoring of travelers who becomes ill over-

seas and electronic transmission of medical data back and forth.

Statements made to describe the need for better communications between travel medicine practitioners and their clients abroad include: "It is a little embarrassing that we are no further along with remote monitoring of our travelers", and "The way we care for travelers today is like surgeons performing pre- and post-operative procedures but foregoing the surgery," referring to the hiatus in care while clients are traveling. But there appears to be marked differences in how available practitioners make themselves for giving advice, and if indeed giving advice to travelers far from home is all that helpful.

For example, most of the respondents offer telephone and e-mail advice, but only about half are available 24/7. "I only give out my daytime office number. Only a select few [travelers] get my home number and cell phone... those that are high risk for any special reason."

"I take calls but only on standard "work" days. Once I am in contact with a specific traveler who has a problem by e-mail, I will monitor e-mails several times a day, even from home over weekends and holidays. If I then go away, I'll pass the thread to another staffer. Occasionally we get phone calls, but usually from an intermediary who is in the U.S. I've actually had an email "conversation" in real time with a patient who had traveler's diarrhea, and who was e-mailing me from an internet cafe in India."

“...Travel medicine practitioners have widely different conceptions of the term telemedicine.”

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ISTM Elections 2005 and the Nomination Process

*Prativa Pandey, M.D.
ISTM President-Elect
Chair, Nominating Committee*

It is time to move forward on organizing the ISTM election for 2005. Two Counselor positions and the position of President are open. Each Counselor position is for four years. The President position is for a two-year term. However, the president serves as President-elect for two years preceding his/her term and then for two years after the term as Past-President (for a total of six years).

A nominating committee, in accordance of criteria set out in our bylaws, has been formed by the Executive Board. Members may propose themselves or propose other member for nomination by filling out a simple form which will be posted on the website by April 2004. Any ISTM member with paid up dues is eligible for nomination but it is desirable for the candidate to have the following qualifications:

- Prior service on ISTM committees or ISTM sponsored initiatives

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“We have 600-800 students who participate in off-campus programs overseas each year. We provide e-mail and phone contact during regular office hours.”

“I give my travel patients my e-mail and a few have used it to get refills or questions answered while out of the country. A more common source is the “stateside spouse” who calls with a question or request. I have had only a few calls/e-mails each year, but my travel practice is new and small. I think it is important if we have the capabilities to handle it [telemedicine]. I prefer email due to convenience factors.”

“Travelers can leave a message 24 hrs. on my direct line. They can reach someone through our centralized HMO number (recently published to all members).”

The general feeling among a majority of respondents appears to be that it is “nice” to be available by e-mail and telephone, but that such communications “do not resolve serious medical situations and rarely, if ever, save lives.”

“Telemedicine is important because it is often the only means available to triage a medical situation and see if it requires medical evacuation and immediate treatment, as well as a means of providing medical stabilization until more adequate care can be obtained. We instruct our patients to call us by telephone if needed for acute medical emergencies, and to e-mail us for less acute problems. We promise a return telephone call within one hour and a return e-mail within 24 hours. Our telephone system is set up to page the physician on call any time a message is left on the voicemail, and we monitor our e-mail 16 hours daily. With the increasing use of cellular and satellite telephones, we are seeing a steady increase in the use of these systems, plus a steady increase in the volume of e-mails.”

“Our organization regularly sends staff on mission travel (35,000 to 40,000 mission days per year) throughout the world, mostly to Asia, sometimes to very remote areas with basic or non-existing medical facilities. In these conditions, the mildest

pathology quickly becomes a source of anxiety and the patient needs prompt reassurance. Distrust in local facilities (however developed they might be) and/or local doctors is a common feature of many expatriates and travelers. A simple contact through phone call to their regular doctor is often sufficient for the patients to cool down and get necessary reassurance. It is of course sometimes impossible for the doctor to have a clear idea of the situation and diagnosis, but a call will at least guide the patients through the steps to follow in order to get the right medical attention. This is particularly obvious in countries and areas where few doc (tors) can speak English.”

“I encourage my travelers to call me. It gives me a better picture of what goes on while they are overseas and helps me refine ... my advice giving skills.”

“The problem of staying in touch with travelers overseas is a HUGE pet peeve of mine. I shiver to think of how many of my colleagues try to do good by giving their patients the all clear to call/email 24/7 but know that most of them (the travel medicine professionals) cannot provide what travelers really need. It may seem comforting to the traveler that they have our numbers/e-mails but we must ask ourselves what we will do for them at 2 AM when they have chest pain, a broken leg or a high fever. In our clinic, we counsel each traveler about the importance of a good medivac policy/assistance plan as a safety net. These providers are fully equipped to handle, triage, refer, monitor, evacuate 24/7. We have a listing of such vendors and encourage our travelers to do homework to find which one best meets their needs. Most of us are NOT equipped to handle this and we need to know our limits. We should not give travelers expectations of care that we cannot meet. It may be a huge potential liability for us as providers. Therefore we do not have a system for travelers to contact us. Occasionally we will get a call anyway. If they do not have a medivac vendor we will try to get them the embassy/consulate telephone number.”

Book Review

Dominique Tessier, MD, Montreal

Les Maux du Voyage
Dictionnaire de médecine des Voyages
Société de Médecine des Voyages
Adimi /Edisan

This French-language, travel medicine textbook/guide is a useful tool for travel medicine practitioners. There are long sections on the basic ABCs of travel medicine, a long description of common and less common words used in travel medicine, and a geographically-arranged section with specific recommendations regarding immunizations and malaria prophylaxis, and epidemiological information.

The book’s “dictionary” format consists of a description of a word, most often a disease or risk for the traveler. When applicable, preventive measures, diagnostic tools and treatment options are described. There are many illustrations and maps illustrating endemic areas for specific infections. There is a comprehensive index arranged by words and country.

But since this book is arranged as a dictionary, the information is organized in alphabetical order and a reader wishing to review all vector-borne diseases, for example, would need to know their names of those diseases to start. The book requires basic knowledge of travel medicine to be useful.

This book with CD is a useful tool for travel medicine practitioners.

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In fact four responders stated that they are “hooked up” with a medivac/assistance company and that they “instruct” their clients to call the company, not them, directly, and to do so whether the issue is trivial or life threatening.

Some travel health practitioners also see telemedicine as a legal minefield:

“Horrendous potential medico-legal pitfalls. Even with electronically transmitted data, ECGs, etc., there is no substitute to having a real patient in your consulting room. The traveler should attend a doctor or hospital in the country visited, even if that means helicopter evacuation. The only role I see myself playing would be to provide information on the patient’s medical history to a doctor abroad but not to take responsibility for my patient’s care in a foreign country.”

“While telemedicine may be important in the future, presently its availability is not spread enough for travelers to easily find a telemedicine facility in countries where they would really need it. In countries where telemedicine is widely available, it is usually easy enough to find medical facilities good enough to diagnose and treat most problems a traveler could experience and it is unlikely that they will need telemedicine.”

“Telemedicine is of limited importance – many health problems that crop up may not be travel-related and may be outside the travel medicine provider’s area of expertise, whereas a single call to a travel insurance help line may be a faster track to appropriate advice. Really depends on the exact nature of the problem. Also depends on the exact definition of telemedicine: are we talking primary care and advice here, or secondary referral with pictures, diagnostic images or ECGs for interpretation?”

“While I think there are obvious applications for acute diagnostic values for cardiac care or orthopedic care where timeliness is essential, providing needed care must be a companion piece to diagnostics. Traveling involves risk; this is one of its inherent compelling characteristics.”

“As there is more international travel for business and pleasure, there will inevitably be more teleservice medicine, by necessity. The globe is shrinking. High tech companies here are using many more workers in India, creating a new concept of ourselves as global citizens. If people in the USA call India now for technical advice, catalogue ordering, etc. something tells me they will soon be calling India for medical advice as well. But the step in between may involve those of us in travel health.”

A few responders believe that the International Society of Travel Medicine (ISTM) may be able to play a role in telemedicine:

“Am not doing this [telemedicine] at this time because my malpractice insurance costs would be high and my current insurance doesn’t cover it. Perhaps we could get a group insurance policy thru ISTM.”

“What is needed is a network of travel medicine clinics and doctors in all places mostly visited by travelers. This network could be interactive and more effective than telemedicine as it presently works. Telemedicine is probably another possible good option for the future, but it will long be limited by unavailability in remote areas, cost, and difficulties of connection.”

“Let’s work on a network of travel physicians with central routing (a live telephone exchange) for contact. This way there will always be a “doc on call”. The cost per year to us would be minimal with 20 or more participants and the service would be extraordinary. We could even develop a link to air evac and travel insurance companies.”

A large number of travel clinics are not set up for giving advice to travelers overseas:

“We are a Public Health Unit and are nurses who do pre-trip counseling and vaccinate. We do not do post-trip follow up other than completing vaccination series.”

Another frequent comment: while the technology to transfer sophisticated medical data between any two locations in the world – and to and from space – is avail-

able, making practical use of the technology is another story:

“The remote medical monitoring of clients/patients may be far more complex than many of us realize and is probably way beyond the one-on-one clinic-to-patient tracking across the planet for the foreseeable future, at least.”

“I am in contact with groups that are monitoring small numbers of patients, using devices that connect to the phone lines for daily data uploads. Those experiments are facing two problems, problems which will only get worse as the number of patients on monitors increases, and as the data flows become more “real time” and less “snapshot”. Problem 1 is data analysis. There are not the bodies (people) to collect and analyze the data, and costs are prohibitive. Problem 2 is that the care givers (doctors, clinics) cannot process the summary data that is fed to them on a regular basis (just too much even for a handful of patients) and are even less able to handle data that - if read - calls for immediate attention. The only solution is some sort of middleware (software sitting between the monitoring site and the decision makers) that does two things. First, it processes large and complex data flows quickly (in real time). Second, it provides output that is usable for medical decision making. Some sort of “triage” process is needed to divide clients into: no problem; on watch list; and attend to now; along with a tool - in our case a virtual construction of the patient - so that data arriving at the doctor’s attention (or the patient’s attention) is readily useable.”

Several responders suggested that travel medicine practitioners should explore the potential of videoconferencing, a technology already widely available, and one that could be very useful to stay in touch with groups of travelers and expatriates, for example.

If you have additional comments on telemedicine, please send them to: Editor, NewsShare, at travhealth@aol.com.

(Karl is the editor of NewsShare and webmaster for the ISTM. He frequently writes about travel medicine for both health care professionals and the media.)

“ISTM Elections 2005 and the Nomination Process,” continued from page 1

- Publication of travel medicine-related clinical or research articles in the Journal of Travel Medicine, other journals or books
- Contributions to the biannual CISTM
- Leadership experience working with national or international professional societies or groups
- Professional experience in the field of Travel Medicine

For each open position, the nominating committee will carefully review all the names submitted and will select the names of 2 nominees most suitable to appear on the ballot in accordance with the bylaws of the ISTM. Ballots will go out to all members with the October 2004 membership mailing. Election results will be announced at the membership assembly in May 2005, in Lisbon.

To maintain true diversity in an international society like ours, our by-laws mandate that geographic considerations are taken into account. The Society bylaws state that no more than three of the seven elected members of the Society shall reside on the same continent. The following paragraphs pertaining to the election process are quoted from the bylaws to increase an understanding of this process:

Article 8.1 A nominating committee will be composed of 7 members in good standing in the Society representing, insofar as possible the various continents and constituencies of the Society (e.g. nursing, academia, private practice). Members of the nominating committee will be appointed by the Executive Board one year before the next Membership assembly and for a term of one year. Two members of the nominating committee will be outgoing counselors and the chairperson of the committee will be the President – Elect.

Article 8.2 Six months before the next Membership assembly, the nominating committee shall submit to the Secretary-Treasurer the names of two nominees for each office to be elected. At least three months prior to the annual meeting, the Secretary-Treasurer shall send a ballot to each member eligible to vote. The ballots shall be returned to the Secretary –

Treasurer. To be valid a ballot must be received by the Secretary-Treasurer at least six weeks prior to the membership assembly.

Article 8.9 No more than three elected members of the Executive Board shall reside on the same continent when elected. The sequence of the elections will be President, President-Elect, then counselors. If three members residing on the same continent are elected, those proposed later in the sequence of elections will drop out as supernumerary candidates; within the counselors, the ones having received less votes will drop out.

By unanimous votes each of the previous Executive Boards has reiterated that all elections are guided but not bound by the following considerations:

1. The President-elect should be elected from a different continent than the current President-elect.
2. One of the counselors should be a nurse counselor who should be elected from a continent different from the continent of the outgoing nurse counselor.

Please note that your nominations should be guided by the interpretation of Article 8.9 and the geographic composition of the Executive Board in 2005 at the time of election.

Geographic Composition of the Executive Board in 2005 at the Time of Election

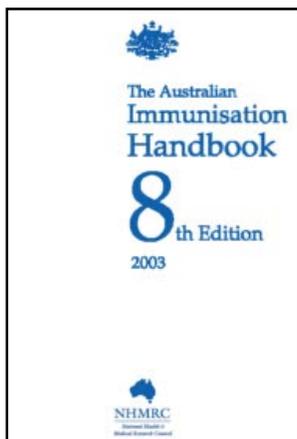
Past President	Bradley Connor	North America
President	Prativa Pandey	Asia
President-elect	To be elected	Should be non Asia
Counselor	Kevin Kain	North America
Counselor	Eli Schwartz	Asia
Nurse Counselor	To be elected	Should be non-Europe
Counselor	To be elected	Open (but would be non-North America if either the President-elect or Nurse Counsellor is North America)

The nominating committee consists of:

1. Prativa Pandey, MD, (NEPAL), President elect-chair
2. Fiona Genasi, RN, (UK), outgoing counselor
3. Peter Leggat, MBBS, (AUSTRALIA), outgoing counselor
4. Alan Spira, MD, (USA)
5. Susan Kuhn, MD, (CANADA)
6. Blaise Genton, MD, (SWITZERLAND)
7. Susan Bailey, RN, (USA)
8. Victor Kovner, MD, (USA)
9. Rogelio-Lopez-Velez, MD, (SPAIN)

Australian Immunization Update

Jonathan Cohen, MD



The Australian Immunisation Handbook 8th edition was recently updated (Sept 2003) and endorsed by the National Health and Medical Research Committee (NHMRC) (<http://immunise.health.gov.au/handbook.htm>). Utilising an evidence-based approach, a number of changes have been made which affect Australians intending to travel overseas, inbound travellers intending to reside in Australia for longer periods, and travellers on their way to developing countries via Australia.

The Australian Standard Vaccination Schedule (ASVS) lists a number of vaccines routinely recommended by the NHMRC, some of which are funded under the National Immunisation Program (NIP). Changes to the ASVS are listed and there is also a new chapter specifically dedicated to overseas travel.

The main changes to the ASVS are:

1. The 18 month dose of acellular diphtheria-tetanus-whooping cough vaccine DTPa (Infanrix) is no longer given.
2. Conjugate pneumococcal vaccine 7vPCV (Prennar) is recommended for all children at 2, 4 and 6 months of age. The vaccine is currently funded only for children under the age of 5 years with specified predisposing risk factors.
3. Acellular diphtheria-tetanus-whooping cough vaccine dTpa (Boostrix) is given for 15 - 17 year olds.

4. Varicella vaccine is recommended for all children at 18 months of age, with a catch up dose for adolescents 10 – 13 years without a history of infection or vaccination. This vaccine is not currently funded under the NIP.
5. Inactivated polio vaccine (IPV) is recommended rather than oral polio vaccine (OPV), however, either is appropriate. IPV for paediatric use is expected to become available within a combination vaccine, but is not funded under the NIP as a separate vaccine.

Haemophilus Influenzae B (HiB) continues to be given routinely within the early paediatric schedule.

Universal vaccination for neonatal and adolescent groups is now routine in Australia.

Meningitis C is given at 12 months of age.

Measles-Mumps-Rubella (MMR, Priorix) continues to be recommended as a two dose regimen in the paediatric schedule. A one time booster dose is recommended for anyone born after 1966 (when measles vaccine was introduced into Australia) who does not have two documented doses of the vaccine or who has not been infected.

Influenza and Pneumonia vaccination continues to be recommended for at risk groups, with influenza vaccination to be considered for travel to the Northern Hemisphere winter season.

For overseas travel

DTPa is recommended for individuals between 8 – 50 year of age and ADT for over 50, if travelling to areas where health services may be difficult to access and more than 10 years have elapsed since their last dose of tetanus.

Whilst the 5th dose of polio is no longer recommended, a booster dose should be given to travellers to areas or countries where poliomyelitis is epidemic or endemic. This particularly applies to the Indian subcontinent, parts of Africa and the Middle East. Sabin OPV can be given but not as a primary series, or if the per-

son or household contact is immunosuppressed, in which case IPV is recommended.

Hepatitis A is recommended to virtually all travellers to endemic areas, i.e. most developing countries. Screening for hepatitis A IgG may be cost effective for those born prior to 1950, if born overseas, or with a past history of unexplained jaundice.

Typhoid vaccination is only recommended for travellers at risk, i.e. travelling to endemic countries where hygiene is poor or drinking water is unsafe. It is not currently known when and if an oral medication will again become available in Australia.

Japanese B Encephalitis vaccination is recommended for travellers spending more than 4 weeks in rural areas of Asia, particularly if travel is during the wet season, and if spending a year or more in Asia, even in urban areas. The risk is much greater if spending time near rice paddies and pigs. Western Papua New Guinea is now included in at risk areas, with inadequate knowledge about adjacent areas. In view of the increased risk of significant side effects, vaccines should be advised to remain within “ready access” to medical care for 10 – 14 days post vaccination.

Rabies pre-exposure prophylaxis is strongly recommended for expatriates and travellers who will be spending prolonged periods (i.e. more than a month) in rural parts of rabies endemic areas (Thailand and India and most developing countries, for example), or if working with animals. Whilst emphasising that the injections should be given deep subcutaneously or intramuscularly, the guidelines recognise the WHO practice of supplying vaccination intradermally where the cost of the vaccine is prohibitive. In this situation, the vaccine should be given under the following conditions:

- by a practitioner familiar with and well-versed in the procedure

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—“Immunization Update,” cont. from p. 5 —

- in the absence of immunosuppression
- in the absence of concomitant administration of chloroquine or related medications
- with serum rabies antibodies being performed 2 – 3 weeks after the 3rd dose

Post exposure treatment is discussed in detail and likewise should be treated by a practitioner familiar with the management. In this instance, both the vaccine and immunoglobulin are available from the local state or territory health department at no charge to the traveller.

BCG vaccination is noted to be highly effective in children, particularly those under 5 years of age and for whom it is primarily intended if living in areas of high endemicity (>100 per 100,000) for more than 3 months. The benefits of BCG in adolescents and adults is less certain with efficacy ranging widely from 0 to 80%. Serial Mantoux testing and the newer Quantiferon™ test are likely to be of greater value in other groups.

A yellow fever vaccination certificate is required from travellers over 1 year of age entering Australia within 6 days of having stayed overnight or longer in an infected country, as listed in the Weekly epidemiological record.

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Report from the African European Travel Medicine Conference

Karl Neumann MD, FAAP



Cape Town, South Africa.

The several hundred North American, European, Asian and Australian travel medicine aficionados who made the long trek* to the southern tip of Africa to attend the first African European Travel Medicine Conference were well rewarded for their efforts. The Conference, organized by the South African Society of Travel Medicine (SASTM), in cooperation with the International Society of Travel Medicine, attracted more than 600 attendees, with about 150 delegates from South Africa and another 100 from other African countries. Forty speakers presented the very latest material in travel medicine as well as reviews of important issues, with emphasis on topics pertinent to the African continent.

SASTM was founded in 2000 and has grown to 210 members. The Society holds two meetings a year, organizes courses, and is very active in disseminating information to further their commitment: safe and healthy travel, especially in Africa. Most SASTM members have traveled widely in Africa, are intimately familiar with the health problems that exist on the continent, and are aware of the resources that travelers can avail themselves of in case they become ill.

The Conference itself was a seamless success. The opening reception was held under the stars in the large, high-walled, inner courtyard of the pentagonal-shaped Castle of Good Hope (Fort de Goede Hoop), built by the early Dutch settlers

more than 300 years ago. On instruction from the Dutch-East India Trading Company, the pioneers set up a port of call for their ships to stock up on provisions, in part to prevent scurvy and other illnesses associated with long sea voyages. The Castle of Good Hope is the oldest building in South Africa.

In contrast, the Conference was held in the just-completed, ultra modern, glass-walled Cape Town Convention Center with its plush-seat auditoriums. The Center is connected to a new, ultra-modern hotel, with other hotels across the street. And only a short walk away is the Victoria & Alfred Waterfront, South Africa's most visited destination. The waterfront has magnificent sea and mountain views, exciting shopping and entertainment opportunities, and a marina. And literally above it all in Cape Town is the flat-topped Table Mountain, often described as magical and mystical, Cape Town's most prominent feature and a world famous landmark.

But neither fabled mountain, nor great shopping, nor open air restaurants on the waterfront, nor near-perfect weather – especially appreciated by escapees from the Northern Hemisphere's winter – enticed attendees from the task at hand, learning travel medicine. Meeting halls were full and exhibit and poster areas bustling. There was camaraderie as attendees, literally from every corner of the world, exchanged ideas, humor, and addresses. Likely, neither books nor journals nor the web will ever replace meetings of people.

* Trek, appropriately, is a South African (Afrikaans) term. It originally referred to arduous journeys, usually by ox wagon. The most famous trek, The Groot (Great) Trek took place in the middle of the 19th century when about 12,000 Boers (people of Dutch descent) left the Cape Colony, the area around present day Cape Town, to migrate north into the interior of the country, where they remained in the highveld, forming isolated communities.

Calendar: Travel Medicine Conferences, Courses & Educational Travel

(Note: This calendar is a service for the travel medicine community. The listings come from reputable individuals within the community but are not checked or necessarily endorsed by ISTM.)

Conferences

March 8
2004
Feb
2005

Postgraduate Diploma in Travel Medicine by Distance Learning. Glasgow, UK. March 8, 2004-February 2005. Year long, distance-learning course for qualified medical practitioners, nurses and other health care professionals with special interest in travel health. Diploma qualification awarded through Royal College of Physicians and Surgeons. Students may be invited to continue onto MPhil in Travel Medicine through the University of St. Andrews. Overseas students particularly welcome to apply. Contact: Miss Amanda BurrIDGE, Course Administrator, Travel Health Department, Scottish Centre for Infection and Environmental Health, Clifton House, Clifton Place, GLASGOW, G3 7LN. Tel: 0141 300 1132. Fax: 0141 300 1170. Email: Tmdiploma@scieh.csa.scot.nhs.uk. Web address: www.travelcourses.scieh.scot.nhs.uk.

March
29-
April
3

Havana (Cuba) Travel & Tropical Medicine Course). March 29 - April 3, 2004. November 1-6, 2004. March 14-19, 2005. Organizer: Instituto de Medicina Tropical "Pedro Kouri" in collaboration with Medical Services for the Tropics, Maastricht, Netherlands. For physicians, nurses, and other health professionals, especially those desiring a review course. Special curriculum for students (at reduced fee). Lectures by Cuban and other experts. Includes visits to hospitals, research laboratories, and health centers. Training available in bacteriology, parasitology, and public health. Language: English. CME (20 hours) from Dutch accreditation authorities. Course Coordinator: Peter de Beer, MD, (PO Box 1660, 6201 BR Maastricht, Netherlands. Email: mstropics@planet.nl; website: www.tropenkliniek.nl) and Dr. Nereyda Cantelar of IPK.

March
29-31

4th European Conference on Travel Medicine (ECTM4). Rome. March 29-31, 2004. Travel Medicine and Safety. Sponsored in part by WHO and CDC, Atlanta. An interdisciplinary approach to travel medicine, preceded and followed by meetings held in close collaboration with leading societies in dermatology, occupational health, sports medicine, pediatrics, psychology and psychiatry, environmental health, cardiology, and other subjects. These meetings will be held in Venice and in other Italian cities of cultural interest. Abstracts accepted from those wishing to take part. Send abstracts to: wpasini@rimini.com by November 30, 2003. Other information: Expomedia Srl, Via XXVIII Luglio 218, 47893 Borgo Maggiore, Republic of San Marino. Tel. (+378)907577, fax (+378)944795, e-mail: info@expomedia.sm.

April
2-12

International Medical Conference. April 2-12, 2004. Punta Arenas, Patagonia, Chile. A fully accredited Continuing Medical Education interactive seminar on Travel Medicine with emphasis on travel to South America. Organized by Dr. Carrie Beallorand and Dr. Kevin Kain of The Centre for Travel and Tropical Medicine and the University of Toronto. Opportunity to enjoy beautiful Los Torres del Paine National Park in Patagonia and cruise to Tierra Del Fuego. Information: Americas Adventures and Study Tours, 1515 Bayview Avenue, Suite 200, Toronto, Ontario, Canada M4G 3B5. Telephone: 1-866-564-1226. Fax: 416-322-0541. Website: www.asiaadventures.ca/americas/chile.html.

April
25-28

Wilderness and Travel Medicine. Santa Fe, New Mexico. April 25-28, 2004. Sponsored by the Wilderness Medical Society. Contact: WMS, 3595 East Fountain Blvd., Suite A-1, Colorado Springs, CO 80910 USA. Tel: +1-719-572-9255. Fax: +1-719-572-1514. Web address: www.wms.org.

May
9-11

The 4th Scandinavian Forum for Travel Medicine. Stockholm, Sweden. May 9-11 2004. In collaboration with the International Society of Travel Medicine. Discussions of practical and theoretical aspects of traditional travel medicine with emphasis on challenging development such as new vaccines in the pipeline, new drugs for combating malaria, new travel destinations, and the special traveler. Meeting language: English. Information: www.infektion.net/travelmed/organisation.html

May
26-28

Tropical Medicine: A Clinical and Tropical Review. Montreal, Canada. May 26-28, 2004. Expert faculty. Didactic, interactive, problem oriented. Clinical vignettes. For physicians and nurses responsible for health of travelers, immigrants, expatriate workers, volunteers and missionaries. Simultaneous English/French translation (earphones). Hands-on diagnostic parasitology laboratory available. Information: Kelly Glover, CME McGill University, tel: (514) 8253; fax: (514) 934-1779; email: kelly.glover@muhc.mcgill.ca. Website: <http://www.medicine.mcgill.ca/tropmed/txt/May%20schedule.htm>

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“Calendar,” continued from page 7

May 31-
June 3

II International Congress on Dengue and Yellow Fever. Havana, Cuba. May 31–June 3, 2004. Sponsored by the Institute of Tropical Medicine “Pedro Kourí” (IPK) and many Cuban and international health associations including WHO and PAHA. Discussions include: vector biology and ecology; socio-economic factors, physiopathology; vaccinology; genetics; laboratory diagnosis and many other topics. Contact: congreso.dengue@infomed.sld.cu

July
8-10

Asia Pacific Forum on Tropical Health Innovation. Cairns, Australia. July 8-10, 2004. Organized jointly by Queensland Government, University of Queensland, The Australasian College of Tropical Medicine, James Cook University and others. Meeting targeted at professionals, scientists and managers working in tropical medicine and international health, especially related to Asia-Pacific. Experts from all parts of the world will present latest in tropical medicine and international health. Interactive sessions/workshops. Wonderful Great Barrier Reef coast setting. Contact: Pauline Fraley at the Queensland Institute of Medical Research: paulineF@qimr.edu.au. Visit: <http://acithn.qimr.edu.au/asia-pacific>

Oct
4-7

5th Asia Pacific Travel Health Conference. Kuala Lumpur. October 4-7, 2004. Theme: Emerging Disease: Impact on Health. Comprehensive scientific program from country-specific issues to global threats. Meeting aimed at professionals with interest in travel health. Information: Med Tech Media (M) Sdn Bhd, Plaza 138, Suite W6.08, Jalan Ampang, 50450 Kuala Lumpur, Malaysia, Tel: +603 2162 9098 Fax +603 2162 9078. Email: 5apthc@meditech.com.my Website: www.5apthc.com

Nov
7-11

53rd Annual Meeting of the American Society of Tropical Medicine and Hygiene. Miami Beach, USA. November 7-11, 2004. Contact: ASTMH, 60 Revere Drive, Suite 500 Northbrook, Illinois 60062. Tel: (847) 480-9592; Fax: (847) 480-9282. E-mail: astmh@astmh.org. Web site: <http://www.astmh.org>.

May
1-5

9th Conference of the International Society of Travel Medicine (CISTM). Lisbon. May 1-5, 2005. Biennial meeting of the International Society of Travel Medicine. More detailed information about the meeting will be available soon. Contact: Frank von Sonnenburg, Section on International Health, Georgenstrasse 5, D-80799 Munich, Germany. Tel. +49 89 2180 3830. Fax: + 49 89 33 60 38. Email: istm_europe@csl.com Website: www.istm.org

May
8-13

8th International Symposium on Maritime Health. Rijeka, Croatia. May 8-13, 2005. (Biennial) Organized by International Maritime Health Association and local organizers, with support from WHO, IMO, ILO and ITF. For health professionals, educators, and legislators. Faculty of international experts. Conference held aboard cruise ship originating in Venice, sailing along Adriatic coast, and visiting the cities of Rijeka and Dubrovnik. Official language: English. Contact: 8th ISMH Secretariat, RI-AK, Verdieva 6, 51000 Rijeka, Croatia. Tel: +385 51 312-312; Fax: +385 51 312-333; e-mail: secrismh8@ri-ak-tours.hr; Web address: www.ismh8.com.

Courses/Educational Travel

June 12-
July 4

Medical Practice for Areas with Limited Resources. Dar es Salaam & Ifakara. June 12 - July 4, 2004. Three-week course in the St. Francis Designated District Hospital in Ifakara and Dar es Salaam, Tanzania. Course uses combination of new teaching theories, advances in knowledge, and realistic medical practice in areas with limited resources to create new educational methods for medical professionals working at the district level in developing countries. Challenging academic and educational atmosphere created by highly motivated expatriate and Tanzanian staff and course participants. Language: English. Contact: Christoph F. Hatz, MD. Swiss Tropical Institute, PO Box, CH - 4002 Basel, Switzerland. Fax 0041 61 284 81 06. Or call: Course Secretariate, Socinstrasse 57, Basel, Switzerland: 0041 61 284 81 06. Email: courses-sti@unibas.ch. Web address: www.sti.ch/kurses.htm.

Jan
17-28

The Gorgas Expert Course. Lima, Peru. January 17-28, 2005 (and every odd-numbered year). Sponsor: Gorgas Memorial Institute. Site: Tropical Medicine Institute (IMT), Universidad Peruana Cayetano Heredia. Admission restricted to those with previous formal training or extensive overseas experience. Given in English. Two weeks of bedside clinical experience in a busy 36-bed tropical disease unit. Includes: 5 hours/day inpatient/outpatient rounds, daily CPC; case presentations by participants/colleagues from around the world. Weekend excursion to the Andes: Verruga Bridge, inter-Andean valleys endemic for bartonella and leishmania; ascent to 4,800m (15,500 feet). Peru has wide spectrum of tropical diseases (see website) and IMT is the major referral center. 80 CME hours. Course Directors: Dr. Eduardo Gotuzzo (IMT) Dr. David O. Freedman, (Gorgas/UAB). Website: www.gorgas.org. Click GORGAS EXPERT COURSE for details and application forms. E-mail: info@gorgas.org.

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the Bimonthly Newsletter of the International Society of Travel Medicine

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