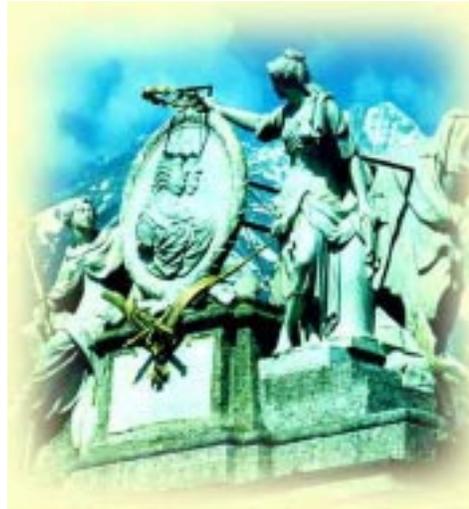




CISTM7 a Huge Success Louis Loutan Becomes President of ISTM Phyllis Kozarsky is President-Elect

Innsbruck, Austria.

The 7th Biennial Conference of the International Society of Travel Medicine held in late May in Innsbruck, Austria was a spectacular, perfectly-orchestrated, finely-tuned success, under the very able direction of Frank von Sonnenberg, (Munich, Germany), the program chairman. The meeting attracted about 1500 delegates from 71 countries, and 500 or so "others" - invited guests, spouses, pharmaceutical representatives, local dignitaries, press people, et al. Festivities began with a memorable opening ceremony that included a stringed quintet playing selections from Mozart and Strauss, and two stirring speeches, one about the problems of tourism at high altitude destinations in host countries, the other about travel being a prescription for hope for the world. This was immediately followed by an outdoor "Welcome-Get-Together" with plenty of local food and drink, and music and dancing, held under starry skies in the "Kaiserliche Hofburg," a large palace courtyard dating back hundreds of years.



But the main object of the attendees was to immerse themselves in travel medicine - and there was plenty of travel medicine to immerse themselves in. From sunup to sundown, it was a marathon program that included lectures, symposia, destination-of-the-day and electronic interactive workshops, debates-of-the-day, free communications, meet-the-professor sessions, working luncheons, satellite programs..... in all, about 200 different speaker presentations, 200 posters and 28 exhibits, social events, and all the other accouterments that are now standard fare at such gatherings. All smoothly and harmoniously synchronized, with numerous programs running simultaneously, thanks to good organization, a knowledgeable scientific program committee, and a well-functioning modern conference facility. Full auditoriums were the rule of the day, everyday. "Time-off," of which there

was precious little, could be spent in the adjacent large, restored medieval town with lots of restaurants and shops and no traffic. With the full cooperation of the weather, attendees spent evenings sitting at one of the dozens of outdoor restaurants, enjoying the schnitzels and the goulashes, the local wines, and, of course, the palatschinkens, Sacher torten, and other Austrian desserts and pastries, and discussing, what else?, travel medicine.

Continued on page 2

Society News

Ron H. Behrens, MD

Cooperation between the travel industry and travel health professionals in the UK.

Beginning in late October the service team admitting malaria patients to The Hospital for Tropical Diseases (HTD), noticed an unusual number of travelers who had recently traveled to The Gambia presenting with falciparum malaria. This pattern was also reflected in the number of telephone enquiries from hospitals across the UK to our clinical staff requesting advice on the management of malaria. During the same period of 1999, a single case of malaria contracted in The Gambia was treated at HTD. A posting to TropNetEurop, a clinical surveillance network of 33 European members (www.tropnet.net), bought immediate reports of similar increases in cases of the disease from The Gambia. Members in Sweden, Denmark, Austria, Germany and Spain also reported an unusual number of malaria cases, many requiring treatment in intensive care units. Surveillance figures of the malaria reference laboratory confirmed an increase of 34% compared with the previous year (1999), which was double that reported in 1998. Four deaths had been notified.

Tourists planning to travel to The Gambia need to be alerted to the increased risk of malaria. A press release to the media led to some articles in the national newspapers. The largest independent tour operator to The Gambia, The Gambia Experience, approached the London School of Hygiene and Tropical Medicine (LSHTM) for support and advice. A meeting between representatives of three travel operators servicing The Gambia, ABTA (the Association of British Travel Agents), and malaria experts of the LSHTM was organized. The tour opera-

Continued on page 11

In this issue..

CISTM7 a Huge Success	1
Society News	1
Letters to the Editors	3
Air Travel and Venous Thromboembolism	5
Visceral Leishmaniasis	7
Calendar	9

“CISTM7 a Huge Success,” continued from page 1

Louis Loutan Becomes President of ISTM Phyllis Kozarsky is President-Elect

At the well-attended closing ceremony, Charlie Ericsson, (Houston, USA) became past president when he handed the presidency over to Louis Loutan, (Geneva, Switzerland). Phyllis Kozarsky, (Atlanta, U.S.A.) became president-elect. She will assume the office of President at CISTM8 in New York in May, 2003.

Louis Loutan, MD, MPH, President, International Society of Travel Medicine

Louis is the 5th President of ISTM, and, as his predecessors, has had a long and distinguished career in travel medicine and related fields. He has a diploma in tropical medicine from the Swiss Tropical Institute (1974), a diploma and doctorate in internal medicine from the Faculty of Medicine of the University of Geneva (1975 and 1984), and a master of public health degree from the Harvard School of Public Health, Boston, USA (1987). He served two years in the Department of Community Health at Tufts University School of Medicine in Boston, and is an assistant professor there. He also heads an ongoing training program in family medicine in Sarajevo, Bosnia (1998-2000).

Louis has been the head of the travel medicine clinic in Geneva since 1989 where he has done research in the immunogenicity of hepatitis A vaccines and various vaccine combinations, and he has organized training programs in travel medicine. His experience in tropical medicine and international health includes 5 years in the Republic of Niger where he conducted clinical work, epidemiological surveys in nutrition and tropical medicine, and organized programs in community health for nomadic populations. He is currently conducting research projects on Leishmaniasis in Eastern Nepal.

Louis is the former president of the Swiss Society of Tropical Medicine and Parasitology, a past board member of ISTM and the Federation of European Societies for Tropical Medicine and International Health, and was the chair of the

organizing committee of the 5CISTM in Geneva in 1997.

One of his special interests is migration medicine. Since 1991, he heads a unit that offers various services for migrant and refugee populations in Geneva, including medical screening, prevention programs, clinical care, care for survivors of violence, and interpreter services.

Phyllis Kozarsky, MD, President-Elect

Phyllis, our president-elect and the first woman to be elected to lead ISTM, grew up in the New York City area, but moved South to Atlanta, Georgia 17 years ago to “take a short break from the crazy NYC life,” and ended up staying there. She has a son, Aaron, with whom she enjoys traveling, outdoor sports, being with friends, and reading. Tucker, their golden retriever, just enjoys being with them!

Professionally, Phyllis is an Associate Professor of Medicine at Emory University School of Medicine in Atlanta, and a faculty member in International Health in the School of Public Health. She has been in the Division of Infectious Diseases for 16 years, spending her time in patient care, teaching, and clinical research. In 1988 she opened Emory’s travel clinic, and since has served as medical director, supervising pretravel care and providing care for a growing number of post-travel patients, immigrants, and refugees. Over the last year, she has spent more time in her activities at the Centers for Disease Control in the Division of Quarantine, serving as a medical expert consultant in traveler’s health. Recently she was appointed chief of travel health. In addition, she serves as consultant to several major corporations including the Coca-Cola

Company, CNN Turner Broadcasting, Delta Airlines, as well as to several missionary and volunteer organizations.

Phyllis has been instrumental in advancing the field of travel medicine both professionally and from a public awareness standpoint. She was co-organizer of the travel medicine conference in Atlanta in 1991, and one of the founding members of the ISTM. Since that time, she has dedicated much time to the growth and development of ISTM, serving as counselor, secretary/treasurer, and chairing and co-chairing committees. She has been a special advisor to the last two ISTM Presidents. Currently, she is a principal investigator on ISTM’s GeoSentinel Network of travel clinics that work to capture information on trends in travel-related infectious diseases. In addition, as Chair of the Professional Education Committee, she has helped the ISTM develop a Body of Knowledge for travel medicine, which can be used for the design of course curricula worldwide.

Phyllis believes that the next decade will be one of potential logarithmic growth for the Society, both in terms of membership, as well as in other areas, and that ISTM should continue to take opportunities to share its wealth of knowledge about travel health with providers as well as with the public. She believes that the Society will need a strategy to increase membership and to encourage active participation from physicians and nurses alike, particularly from those in underrepresented countries. She believes that the Society’s committees will require greater support to explore creative avenues for reaching their goals. And finally, one of the Society’s most important challenges will be to open communications with various other societies with similar interests.

Letters to the Editor

NewsShare useful and informative

Dear Editor:

I found the on-line NewsShare publication to be easy to use and informative.

It would be really great if the Society could produce position papers on various topics and then publish them in the Journal and mention them in NewsShare.

Topics for position papers that haven't already been done could include:

- consensus on preventive measures for altitude sickness;
- indications for rabies pre-exposure prophylaxis,
- antimalarial prophylaxis (despite the data, I find it harder and harder to use mefloquine for shorter trips).

It would also be most useful if we could generate a list of countries where antimalarials are available OTC or per MD's prescription, and at what cost.

For example, I just got a call from a traveler in Cambodia who said that Malarone could be bought OTC for 50 cents a pill. Others have told me that Mefloquine is available in Ecuador and in some other countries for 19 cents a pill, and ditto for chloroquine in Mexico. Obviously, it would be very important to know if such medications are equivalent to ours, i.e. trustworthy.

It would also be very interesting to know why we have to pay such exorbitant prices for these drugs in the U.S. I sometimes have to prescribe mefloquine when I would like to use Malarone, because of cost. If any of your readers have any information or comments on these subjects, I would like to hear from them..

Thank you for the good work. This society is the most useful one I have belonged to.

Kathryn Love, MD, USA

Continued on page 4

Remember to send us news items that you would like to share with your colleagues. Here are some ideas:

- Comments on articles in the literature about your area of expertise. Several paragraphs are sufficient.
- Newspaper clipping and articles from your local medical publications of interest to the world travel medicine community.
- Announcement of meetings dealing with travel medicine and related subjects.
- Notes from your lectures.
- Short articles written by you.
- Other information of interest to our members.

Several members whose native language is other than English have said that they would contribute if their written English was better. Please do not worry about that. Travel medicine is what we are all interested in, not language skills. In fact, we are always impressed how well our non-native English speakers communicate in English. We can help you with language problems in writing - we often do that for our English speaking members, too.

The deadline for the next newsletter/ website posting is August 15th. We would like to have some submissions by that date - but that is not essential. If that date is too soon for you we will use your material in future issues.

*Karl Neumann, MD
Editor/Webmaster*

*Partial reprint from the January/
February Newsletter*

“Letters to the Editor,” continued from page 3

Medical Tourism – Treating patients for their good – or your own?

Dear Editors:

We are expatriate doctors living at 3900 meters in the Mount Everest region of Nepal and running a health care system serving a population of 10,000. The area is remote, mountainous, and roadless, with the villages scattered along high valleys. Over the past 32 years a health system of one hospital and eight health clinics has been established so that most residents are now within an hour’s walk of a clinic or hospital.

The area is popular with tourists. Last year 19,000 visitors came into the Sagarmatha National Park where Mount Everest, the hospital, and five of the eight health clinics are located. Inevitably, there are many doctors and other healthcare professionals among them.

Although the presence of the hospital is well publicized, many doctors touring the area hold ad hoc clinics along the trail. They often conduct their clinics just 100 yards from the local villages’ health clinic. At a time when we are developing the skills of the local resident health workers and increasing the confidence that the local people have in them such misdirected good will undermine progress in the existing health system.

It is inappropriate arrogance to assume that anything that a Western doctor has to offer his less developed neighbor is progress. These tourists are often working outside their trained specialty or have little concept of how that specialty applies to Nepal. They frequently don’t understand local illness presentation, culture, or language. They often offer inappropriate treatment because they think they “must give something.” Such consultations provide little possibility for follow up and the local health providers are left to pick up the pieces with no record of the consultation. If an unregistered Nepali doctor on holiday in the United Kingdom offered general medical consultations in a shopping center there would be a public and professional outcry. The problem is extended when applied to nurses, paramedical staff, and medical students.

Furthermore, legally these doctors are on difficult ground. The Nepal Medical Council is striving to develop and maintain a professional body and requires all doctors who practice in Nepal to register with the council. For certain services, such as family planning, practitioners are required to have Nepali training certificates. This is setting a standard of medical professionalism that is required and respected in the West, so it should be respected in Nepal.

We are seeing the development of medical tourism/exotic travel to a developing region with a brief opportunity to practice medicine on local residents. This seems to occur on two levels. Firstly, doctors travel independently to areas that seem to have no system of health care and, while there, perform good acts. We see this regularly with trekking doctors who give residents short courses of antibiotics, which is fine until you consider tuberculosis control and resistance. Recently, a chest physician gave one of our long term psychiatric patients an injection, but we don’t know what it was. On the other hand, the acts performed in a life or limb threatening emergency are justified, but there should still be follow up with the nearest local provider.

The second level, which is more alarming, is the development of adventure holidays sold to groups of doctors specifically for the purposes of research or providing health care. The most recent example was an American group of two subspecialists and a selection of house officers and medical students who actively sought out patients along the trail without making any prior contact with the hospital and health posts along the way. They brought an ultrasound machine and a microscope. Can you realistically treat chronic disease after a single consultation? But working with the senior doctors we might have used the equipment and instruction with lasting benefit.

Medical work overseas can be constructive. It takes little effort to find out what health care exists in an area and for doctors to work with or refer to the local system. For more long term work there are numerous agencies in industrialized countries which recruit doctors to work in developing countries.

A fundamental principle of medical training is “first do no harm.” If as a doctor or other health care professional you cannot resist the lure of medical tourism and insist on the casual or opportunistic treating of local residents, consider whether you are treating the patient for your own good or for theirs, and whether your actions may actually do more harm than good.

*Rachel A Bishop and James A Litch,
Codirectors and Physicians,
Kunde Hospital, Solukhumbu District, Nepal*

(This letter first appeared in the BMJ- the British Medical Journal. It is reprinted here, with permission.)

Air Travel and Venous Thromboembolism

Bo Eklof, MD, PhD

Alerted by the worrying reports in the media on air travel-related venous thromboembolisms (ATVT) during long-distance flights, the World Health Organization (WHO) arranged a meeting of experts in Geneva, Switzerland on March 12 and 13th, 2001 in order to do the following:

- review the available scientific information,
- define the extent of the problem,
- identify priority areas for research,
- find possible solutions if, indeed, a problem exists,
- attempt to reach a consensus of pragmatic strategies for prevention based on currently available evidence.

The meeting was organized by Shanthy Mendis (Sri Lanka), a cardiologist and coordinator for cardiovascular diseases at WHO's headquarters in Geneva. Nine researchers were invited to present available scientific information under the chairmanship of professor Fred Paccaud, an epidemiologist at the University of Lausanne, Switzerland. In addition, representatives were present from the following organizations: fifteen major international airlines; the International Air Travel Association (IATA), a trade organization to which most international airlines belong; the International Civil Aviation Organization (ICAO), a WHO agency; the European Commission; the Aviation Health Institute (UK); the Airlines Medical Directors Association; the Japan Aeromedical Research Center (Japan); and various other WHO groups.

Here are brief summaries of the presentations of the nine expert participants (with one expert presenting two papers):

Paul Giangrande, MD. Hematologist. Oxford, UK. "Air travel and thromboem-



WHO Head Office Thromboembolism
Photo ©WHO/Pierre Virot

bolism: Is there a link?" There is an association between travel and venous thromboembolisms but the overall risk is low. Prospective studies are required to establish the precise incidence of individuals who have been identified with risk factors. Studies are also required to evaluate the benefit and possible risks of preventive measures which have been proposed - exercise, stockings, aspirin and heparin.

Emile Ferrari, MD. Cardiologist. Hospital Pasteur, Nice, France. "Travel as a risk factor for venous thromboembolic disease." In a case-controlled study of 160 patients admitted for deep vein thrombosis (DVT), 25% had a history of recent travel, 2 by train, 9 by airplane, and 28 by car. The odds ratio for travel related DVT was 4 ($p < 0.0001$), leading to the conclusion that travel alone can produce DVT.

Roderik Kraaijenhagen, MD. Vascular internist. University of Amsterdam, The Netherlands. "Travel and risk of venous thromboembolism." In another prospective case-controlled study of 1911 patients which were investigated for the suspicion of DVT or pulmonary embolism (PE), 32 patients with DVT and 104 controls had

a history of prolonged travel with an odds ratio for travel related DVT of 0.96. Very few patients had traveled by airplane. Their conclusion was that the results did not lend support to the widely accepted assumption that long traveling time is a risk factor for venous thrombosis. However, Harry Buhler, MD, from the same institution showed an extension of this study. When patients traveled more than 10 hours they did have an increased risk to develop DVT.

John Scurr, MD. Vascular surgeon. Middlesex and University College. London, UK. "Traveller's thrombosis - Is there a link between long haul flying and deep vein thrombosis?" This was a prospective, randomized study of 200 passengers, not yet published, where 10% of those without stockings developed asymptomatic calf vein thrombosis, while not one of the passengers with stockings developed DVT. Four percent of those with stockings, however, developed superficial thrombophlebitis in varicose veins.

Patrick Kesteven, MD. Hematologist. University of Newcastle, UK. "Air travel and venous thromboembolism: gaps in current knowledge". The author concluded - based on his own study and that of the literature - that the association between travel and thrombosis is real. Most cases with DVT have other risk factors for DVT. The incidence of traveler's thrombosis amongst patients with DVT ranged from 3.2% to 17.3%. The incidence of traveler's thrombosis in north-east England was 0.4 cases/10,000 population annually.

Continued on page 6

“Air Travel and Venous Thromboembolism,” continued from page 5

“...there are insufficient scientific data on which to make specific recommendations except, perhaps, for exercising the legs during travel.”

Bo Eklof, MD. Vascular surgeon. Straub Clinic and Hospital and the University of Hawaii, USA. “High priority research areas to confirm association and identify possible preventive measures for venous thromboembolic disease associated with air travel.” Research on predisposing risk factors for ATVT show that these factors influence the Virchow triad for the development of thrombosis: endothelial lesion, hypercoagulability and stasis. The risk factors were divided into patient related internal risk factors and cabin related external risk factors. Patient related risk factors were: older than 60 years, obesity, previous DVT/PE, recent surgery or injury, pregnancy or less than two months post partum, malignancy, cardio-respiratory disease, other chronic disease, estrogen medication (oral contraceptive pill/hormone replacement therapy), varicose veins, and thrombophilia. Ninety-two percent of these patients with ATVT had at least one of these risk factors with an average of 3 risk factors.

Cabin related risk factors were: immobilization, coach position, low air pressure with relative hypoxia and dehydration due to low humidity. There were objections from some airlines representatives regard-

ing the existence of dehydration. Several research projects on incidence and prevention were suggested.

Charles Forbes, MD. Hematologist. University of Dundee, UK, “Some considerations for prevention of venous thrombosis while flying.” None of the preventive measures have any evidence base whatsoever. However, risk stratification may be the basis for advice that should be followed.

William Toff, MD. Hematologist. University of Leicester, UK. “Research: Priorities and future directions.” There is a sound theoretical basis to infer an association between air travel and an increased risk of venous thromboembolism. The priorities for future research should be: confirming the apparent association between air travel and DVT, quantifying the strength of the association in subjects with and without intrinsic predisposition to determine the appropriate methods to stratify risk, identifying culpable factors in the flight environment, exploring the mechanistic basis of the association, and identifying and evaluating effective preventive measures for subjects at risk.

The confirmation and quantification of the postulated association between air travel and venous thromboembolism will require a large-scale epidemiological study. Studies of culpable factors in the flight environment (cabin related external risk factors), in particular hypobaric, hypoxia and dehydration could be studied in a hypobaric chamber. A collaboration with the Royal Air Force in the Midlands of the UK is already underway. The efficacy of therapeutic interventions should be assessed either in the hypobaric chamber or during long-haul flights. Interventions to be considered would include exercise programs, use of compression stockings, aspirin and low molecular weight heparin.

Frits Rosendaal, MD. Clinical epidemiologist. University of Leiden, The Netherlands. “Thrombosis related to long-distance flights: Considerations for research.” Venous thrombosis in the general population occurs in 1 per 1,000 individuals per year with a steep age-grad-

ient from 1/100,000 in children, 1/10,000 in adults aged 20-50 years, 1/1,000 in those aged 50-70 years to 1/100 in the very old. Case fatality is 1-10%, and is also age dependent. Research into the association between long-distance flights and thrombosis is relevant to establish the precise risk. Only then can the various recommendations to prevent the conditions be accurately evaluated, and will it be possible to avoid recommendations that may be counterproductive.

Bo Eklof MD, PhD (see above). This is preliminary, unpublished data presented with permission from the first author, Gianni Belcaro. In 355 low risk and 389 high risk passengers traveling economy class for 12 hours, no one in the low risk group developed DVT, while 2.7% in the high risk group did. In a prospective, randomized study involving 833 high risk passengers with the same flight conditions as in the first study, half the group used below knee compression stockings. There were 4.5% DVT in the no stocking group compared with 0.24% in the stocking group. These three studies clearly indicate a high incidence of DVT associated with long-distance air flights with a significant reduction by the use of below knee compression stockings.

Shanthi Mendis, MD, the organizer of the meeting, conducted a comprehensive search of the literature. There were no grade 1 or 2 evidence (meta-analysis or large prospective, randomized studies), so the evidence is limited to grade 3-5 (case-control studies, retrospective studies and expert opinion) including the two published case-control studies that were presented at this meeting. Of these two studies, one indicated a strong association between travel and thrombosis, the other did not find any such association.

A report was finally agreed upon which contains the collective views of the international experts, including discussions with the representatives of the airlines and from WHO. Based on the weight of evidence, the summary position at this point was:

Continued on page 8

“Air Travel and Venous Thromboembolism,” continued from page 6

- An association probably exists between air travel and venous thrombosis.
- Such an association is likely to be small, and mainly affects passengers with additional risk factors.
- Similar links may exist for other forms of travel,
- The available evidence does not permit an estimation of actual risk, and therefore public health recommendations cannot be made at the present time.

The representatives of the airlines agreed that an association probably exists, that there are insufficient data on which to make recommendations, and consequently, are committed to support further research. Ideally, such research should be an international epidemiological study involving multi-centers and include a large prospective cohort study. Such a study will likely provide clues to other etiological factors. Also helpful will be studies seeking intermediate endpoints in groups of volunteers examining isolated independent environmental and behavioral risk factors and interventional studies involving passengers prospectively and using objective diagnostic methods and examining various interventional modes.

It was the unanimous view of the group that these studies should be undertaken as soon as possible, under the auspices of WHO and supported by an independent scientific committee in close collaboration with IATA and ICAO.

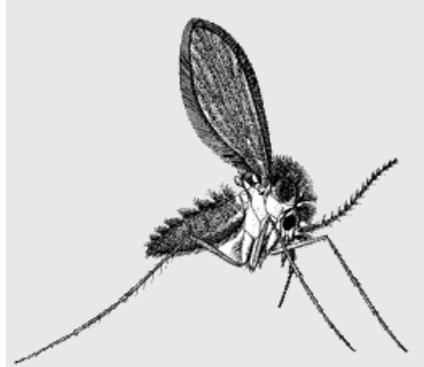
In the meanwhile there are insufficient scientific data on which to make specific recommendations except, perhaps, for exercising the legs during travel. At the present time, in particular in view of the recognized side-effects, indiscriminate use of pharmacological agents cannot be recommended.

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Visceral Leishmaniasis

John D. Cahill, MD



Mediterranean basin. The infection is usually transmitted by the bite (blood feed) of the female sandfly, although human infection has been reported from blood transfusion, congenital transmission, and by sexual intercourse. In the sandfly vectors and on culture, the parasite takes up the promastigote form.

Many different strains of leishmania can cause disease in humans with each strain differing in its reservoir, vector, geographic location, and in the pathological lesions that it gives rise to. (Cutaneous Leishmaniasis will not be discussed here.)

History

In 1900, Major William Leishman performed a postmortem on an English soldier returning from Bengal who had died of “fever.” He described finding enormous numbers of oval bodies 2 to 3 microns in diameter in the splenic smears of this patient. In 1903, Captain James Donovan in Madras, described similar findings in the splenic smears taken from the enlarged spleens of Indian patients who had died, presumably from malaria. It was Ronald Ross who named the new protozoa the Leishman Donovan body. (1)

Epidemiology

The World Health Organization estimates that there are 500,000 new cases of visceral leishmaniasis occurring annually. This number is probably grossly underreported, secondary to poor surveillance systems. Ninety percent of cases are found in Bangladesh, India, Nepal, Sudan, and Brazil. There are 3 distinct species: *L. infantum* - found in the Mediterranean basin, Central Asia and China, *L. donovani* - in India and Eastern Africa, and *L. chagasi* - in South and Central America. Leishmania are members of the family Trypanosomatidae, order Kinetoplastida.

The reservoir of infection is the amastigote form of the parasite, present in animal reservoir hosts such as rodents, dogs, foxes, jackals, and humans. Dogs are especially common reservoirs in the

Pathogenesis

When the promastigote are injected into humans, they are rapidly taken up by macrophages in which they revert to the amastigote form. What then occurs depends on the cell mediated response of the host. In endemic situations there are about 30-100 subclinical infection for every case of visceral leishmaniasis. (2) If spontaneous recovery follows, the patient’s cell mediated immunity increases. Such patients will develop a delayed sensitivity response resembling the tuberculin reaction if a suspension of killed promastigotes is injected intradermally. This is known as the leishmanin or Montenegro test.

If the individual is unable to mount an appropriate immune response, the parasite disseminates in the reticuloendothelial cells of the body. The incubation period can vary from 3 – 18 months. However, the parasite may remain dormant and not present itself until one has a compromised immune system. (3)

Clinical Presentation

Patients tend to present with fever and impressive splenomegaly. Despite high fevers, patients usually feel quite well. Cough is not an uncommon symptom. An immune complex reaction can occur leading to uveitis and nephritis. In India, in-

Continued on page 8

“Visceral Leishmaniasis,” continued from page 7

crease skin pigmentation occurs. Laboratory studies demonstrate a pancytopenia (normochromic/normocytic anemia, leukopenia, and thrombocytopenia), hypergammaglobulinemia, and a low albumin. In endemic regions, pediatric cases are more common. As the disease progresses concurrent infections are common: TB, measles, pneumonia, and brucellosis, for example. Co-infection with HIV is becoming more common in the Mediterranean region and in Brazil. Malabsorption and malnutrition may also be seen. Atypical presentations are common in this population and amastigotes may be found in any organ. Treatment can be difficult, with relapses not uncommon.

Diagnosis

Most patients can be readily diagnosed by directly visualizing the amastigotes in a splenic aspirate. The procedure is relatively simple, tolerated well by most patients, and very rewarding when the diagnosis is made underneath the microscope. One needs to ensure that the platelets and coagulation profile is within normal limits before undertaking this procedure. Amastigotes can also be directly visualized in bone marrow and lymph nodes. A non specific test is the Formol gel test, which is based upon the hyperglobulinemia state of the patient. This author finds the Leishmanin skin test to be of little use in the initial diagnosis. More difficult or expensive tests available include: ELISA, DAT (direct agglutination test), or culture of the promastigotes on NNN or Schneider's medium.

Treatment & Prevention

The mortality approaches 90% for untreated patients, whereas most patients will recover if treated. Treatment for visceral leishmaniasis is expensive and complicated by the fact that current medications are given IV or IM. Traditionally the pentavalent antimony compounds such as Sodium stibogluconate (Pentostam) and Meglumine antimonate (Glucantime) are used. Sodium stibogluconate is available from the CDC in the USA. Duration of treatment for all these agents is generally 28 days. Potential side effects include malaise, GI upset, pancreatitis, prolongation of the QT interval, and headache. (4) Amphotericin B desoxycholate and Liposomal Amphotericin B may also be used. Aminosidine (Paromomycin) can be used alone or along with the pentavalent antimonials for its synergistic action. The first oral agent, Miltefosine is currently undergoing trials. Treatment must also address concurrent infections, anemia, and the nutritional status of the patient.

Post Kala Azar Dermal Leishmaniasis is caused by *L. donovani* and presents with cutaneous eruption of skin nodules or depigmented macules. It is more commonly seen several months to years after treatment in India and East Africa. The Indian variant may last for years and the African variant usually resolves within months. This syndrome can be quite disfiguring and may be mistaken for leprosy.

Prevention is best accomplished by eliminating the reservoirs. Insecticide should be used to decrease the amount of sand

flies. Personal protection with repellants, permethrin-impregnated bed nets, and suitable clothing. Individuals should be advised to, ideally, sleep on the second floor of a building, since the flight of the sandfly is limited to 10 feet.

References

1. Cahill KM, O'Brien W. *Tropical Medicine A Clinical Text*. Mount Salus Press, Dublin, 1989, p33-34.
2. Desjeux P: Human leishmaniasis: Epidemiology and public health aspects. *World Health Stat Q* 45:267-275, 1992.
3. Pampiglione S, Manson-Bahr PEC, Giungi F, Giunti G, Parenti A, Canestri TG. Studies on Mediterranean Leishmaniasis, Asymptomatic cases of visceral leishmaniasis. *Trans R Soc Trop Med Hyg* 1974;68:447-453.
4. Ho M, Siongok TK, Lyerly WH, Smith DH. Prevalence and disease spectrum in a new focus of visceral leishmaniasis in Kenya. *Trans R Soc Trop Med Hyg* 1982;76:741-746.
5. Gasser RA, Jr., Magill AJ, Oster CN, et al: Pancreatitis induced by Pentavalent antimonials agents during treatment of leishmaniasis *Clin Infect Dis* 18:83-90, 1994.

John is a member of the Department of Infectious Disease and Emergency Medicine, Brown University School of Medicine, Providence, Rhode Island, USA. He has contributed several articles to NewsShare.

Calendar

Conferences 2001

**July
19-24**

Medicine for Adventure Travel, 2001. Jackson Hole, Wyoming. July 19-24, 2001. "What do we know, and how do we know it?" A critical look at our sources of knowledge in travel medicine. Faculty consists of leaders in travel medicine. Contact: Nancy Johnsen, Medicine for Adventure Travel, PO Box 28, Kelly, Wyoming 83011 Tel: 1-866-733-4609. From outside U.S.: 1-307-739-6780. Email: mat@wyoming.com Web address: <http://atrav.com/mat>

**August
7-11**

Summer Conference & Annual Meeting of the Wilderness Medical Society. Whistler, British Columbia, Canada. August 7-11, 2001. Sponsor: Wilderness Medical Society (WMS). The theme of the meeting is mountain medicine, aquatic medicine, and backcountry medicine. WMS, 3695 E. Fountain Blvd. Ste. A1, Colorado Springs, CO 80910. Tel: 719-572-9255. Contact: WMS Meetings Plus 1-800-800-6819. Fax: 801-224-5398. Email: wms@wms.org Web address: www.wms.org

**Sept.
14-16 &
28-30
Oct.
12-14**

Wilderness & Travel Medicine for Primary Care Providers. Chicago, September 14-16, 2001. San Diego, September 28-30, 2001. Orlando, October 12-14, 2001. Sponsor: Wilderness Medical Society (WMS), Weekend courses. "In a shrinking world, every primary care provider must be familiar with basic wilderness and travel medicine. WMS, 3695 E. Fountain Blvd. Ste. A1, Colorado Springs, CO 80910. Tel: 719-572-9255. Contact: Email: wms@wms.org Web address: www.wms.org

**October
11-13**

Medizin und Mobilität. Oberpfaffenhofen (near Munich), Germany. October 11-13, 2001. German Society for Aviation and Space Medicine in cooperation with the German societies for mountain and expedition medicine, polar medicine, travel medicine, tropical medicine and diving medicine. Official language: German. Contact: DGLRM-Kongresssekretariat Medizin und Mobilität 2001, Institut für Luft- und Raumfahrtmedizin des DLR, Linde Höhe, 51147 Köln, Germany. Fax: 0 22 03/69 52 11.

**Sep. 30-
Oct. 3**

Challenges in Tropical Medicine and Parasitology. Pontresina, Switzerland September 30 - October 3, 2001. A joint meeting of the Swiss/Italian Societies of Tropical Medicine and Parasitology. Distinguished international speakers will review major problems and achievements in the fields of tropical medicine, parasitology, and travel medicine and provide a forum for the exchange of ideas and data. Contact: Felix Grimm, c/o Institute of Parasitology, Winterthurerstrasse 226a, 8057 Zurich - Switzerland. Fax: +41 (01) 635-8907. Email: sitap@vetparas.unizh.ch/ Web address: www.sstmp.unibe.ch/sitap

**Nov.
19-23**

54th World Congress of the World Thermalism and Climatology Federation (FEMTEC), 2nd Latin American Congress of Tourism and Health (FLT), and 3rd International Congress of Tourism and Health. Varadero, Cuba. November 19 - 23, 2001. The use of natural resources to promote health. Official languages: Spanish and English. Contact: Secretary to the Organizing Committee Margarita Roca Sardina, Ave. 43, No. 1418 Esq. a Calle 18, Miramar, Playa, Ciudad de la Habana, Cuba. Tel: (53 7) 24 7218. Fax: (53 7) 24 1330 Email: despacho@sermed.cha.cyt.cu Web address: www.cubanacan.cu/turismo/salud/index.html

Conferences 2002

**Feb.
10-13**

Winter Wilderness and Travel Medicine Course. Big Sky, Montana, February 10-13, 2002. Cold weather aspects of travel and wilderness medicine. WMS, 3695 E. Fountain Blvd., Ste. A1, Colorado Springs, Co 80910. Contact WMS Meetings Plus 1-800-800-6819. Email: wms@wms.org Web address: www.wms.org

**Feb. 25-
March 1**

8th Swiss International Short Course on Travellers' Health. Basel, Switzerland. February 25 - March 1, 2002. Organized by the Swiss Tropical Institute and under the patronage of the International Society of Travel Medicine A 1-week course providing comprehensive training in all aspects of travel medicine. Official language: English. Contact: Swiss Tropical Institute, Course Secretariat, Socinstrasse 57, CH - 4002 Basel, Switzerland. Tel: +41 61 284 82 80. Fax: +41 61 284 81 06. Email courses-sti@unibas.ch Web address: www.sti.unibas.ch

**May
15-18**

III European Conference on Travel Medicine: Travel and Epidemics. Florence, Italy. May 15-18, 2002. A broad overview of the latest in travel medicine from leaders in the field. Sponsor: WHO Collaborating Centre for Tourist Health. Official Language: English. Contact: Dr. Walter Pasini Viale Dardanelli, 64 47900 Rimini, Italy Tel. +39-0541-24301 or +39-0541-53209. Fax +39-0541-25748. E-mail: wpasini@rimini.com. Or contact: Conference Secretariat: Travel Agency Girovagare, Viale Milton n. 81, I- 50129 Firenze, Italy. Tel: 39 055 494949. Fax: 39 055 476393.

Calendar, continued

**May
22-24**

3rd Scandinavian Forum for Travel Medicine 2002.

Copenhagen, Denmark. May 22-24, 2002. Sponsors: Travel medicine societies in Denmark, Sweden and Norway in collaboration with WHO. A focus on the scientific basis for travel medicine through state-of-the-art reviews, symposia, and free communications. Health risks when traveling to Eastern European countries. Official language: English - with parallel sessions in Scandinavian languages. Contact: Conference secretariat: ICS A/S Copenhagen, Strandvejen 171, P.O. Box 41, DK-2900 Hellerup Denmark. Tel: +45 3946 0500 Fax: +45 3946 0515. Email: forum2002@ics.dk Web address: www.ics.dk

**Sept.
8-12**

Third European Congress on Tropical Medicine and International Health.

Lisbon, Portugal September 8-12, 2002. "Tropical Medicine: A Global Challenge." Under the auspices of the Federation of the European Societies for Tropical Medicine and International Health. Hosted by the Instituto de Higiene e Medicina Tropical. This Conference will concentrate on tropical medicine, travel medicine, migration, medicine, and international health, involving different experts to explore future innovative collaboration. Official language: English. Local Committee Chairman: Professor Dr. F. Antunes, Instituto de Higiene e Medicina Tropical, Rua da Junqueira, 96 PT-1600 Lisbon Tel: ++351-21-365-2638 Fax: ++351-21-797-6242 Email: ip231874@ip.pt www.kit.de/tropical2002/

**Oct.
22-25**

IV Biennial Asia Pacific Travel Health Conference.

Shanghai, China: October 22-25, 2002. Travel Health in the Asia Pacific Region: New Frontiers and Challenges. Sponsor: Asia Pacific Travel Health Society Official language: Official language: English - with simultaneous translation of the plenary meetings into Chinese. Contact: Ms. Zhou Yifan, Secretariat of 4APTHC, Room 1705, No. 2669 Xie Tu Road, Shanghai 200030 China. Tel: 86-21 64398193. Fax: 86-21 64398194. Email: apthc2002@sh163.net Web address: www.2002APTHC.NET

Conferences 2003

**May
7-11**

CISTM8 8th Conference of the International Society of Travel Medicine.

New York. May 7-11, 2003. Contact: CISTM8 Conference Secretariat: Talley Management Group, Inc., 19 Mantua Rd. Mt. Royal, NJ 08061 USA. Tel: (856) 423-7222 Ext 218. Fax: (856) 423-3420. Web address: www.istm.org.

Courses/Educational Travel 2001

**Oct.
3-21**

High Altitude and Tropical Medicine Seminar.

Nepal. October 3-21, 2001. Trekking for medical professionals interested in wilderness medicine. Led by Buddha Basnyat, MD a physician in Kathmandu and a US-board-certified internist who operates the Nepal International Clinic, and directs the Himalayan Rescue Association. He is also an active member of the Wilderness Medical Society. CME-credit approved. Contact: Wilderness Travel, 1102 Ninth Street, Berkeley, CA 94710; 1-800-368-2794 or 510-558-2488 or fax: 510-558-2489. Email: info@wildernesstravel.com. Trip Itinerary available at: <http://www.wildernesstravel.com/wtexp.html#wtxmedic>

Courses/Educational Travel 2002

**Feb.
18-22 &
15-25**

Siem Reap (Angkor Wat), Cambodia.

Conference date: February 18-22, 2002. (Travelling date: February 15-25, 2002.) CME on Travel and Tropical Medicine. Accredited by the University of Toronto. Sponsored by The Centre for Travel and Tropical Medicine, Department of Medicine, Toronto General Hospital. Course organizer: Kevin C. Kain, MD, FRCPC, Director, Centre for Travel and Tropical Medicine, EN G-224, Toronto General Hospital, 200 Elizabeth Street. Toronto, ON, Canada M5G 2C4, Kevin.kain@uhn.on.ca Travel arrangement through: Yue Chi, Concepts East Travel, 120 Eglinton Avenue East, Suite 904 Toronto, Ontario, Canada M4P 1E2 Tel: 416-322-3387 or 1-888-302-1222. Fax: 416-322-3129. E-mail: chiyue@idirect.com

**Jan. 28-
March 29**

The Gorgas Course in Clinical Tropical Medicine.

Lima, and the Andes and Amazon regions, Peru. January 28 - March 29, 2002 *Waiting list only* for this date. Course scheduled for 2003 and 2004. Sponsored by the University of Alabama and the IAMAT Foundation. Includes lectures, case conferences, diagnostic laboratory procedures, and bedside teaching in a 36-bed tropical medicine unit. Official language: English. International Faculty. 380 contact hours. Contact: David O. Freedman, M.D. Gorgas Memorial Institute, University of Alabama at Birmingham, 530 Third Avenue South, BBRB 203, Birmingham, AL 35294. Fax: 205-934-5600 Or call: The Division of Continuing Medical Education at 800-UAB-MIST (U.S.) or 205-934-2687 (from overseas) Email: info@gorgas.org. Web address: www.gorgas.org.

— “Calendar,” continued from page 10 —

**Feb.
3-15 &
Feb. 24-
March**

Tropical Medicine Expeditions to East Africa.

Kenya, February 3 – 15, 2002. Uganda. February 24 - March 2002. Sponsors: Tropical Medicine Center, Cologne, Germany, University of Nairobi, Kenya, and University of Makerere, Kampala, Uganda. Official language: English. Expedition designed for a limited number of physicians, public health experts, nurses. Visits to many hospitals and projects in urban and rural areas. Includes bedside teaching, laboratory work, and lectures in the epidemiology, clinical manifestations, diagnosis, treatment and control of all important tropical diseases. 50 contact hours. Contact: Kay Schaefer, MD. Fax: +49 221-340 49 05. E-Mail: contact@tropmedex.com Website: www.tropmedex.com

— “Society News,” continued from page 1 —

tors agreed to provide more detailed malaria advice to future clients in promotional material and to include malaria warnings and advice within accommodations in their Gambian resorts. The Gambia Experience has also supported the implementation of a case control study into the outbreak, by mailing questionnaires to its clients identified as controls.

This collaboration between travel medicine personnel and the tourist industry is providing a valuable opportunity for health professionals to target health advice to travelers. It has also enabled research into the risk factors that are leading to increased risks of malaria in package tourists to The Gambia which remains a popular destination for many European travelers.

Ron is a Senior Lecturer at the London School of Hygiene & Tropical Medicine, and a Consultant at the Hospital for Tropical Diseases.

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