An Occasional Medical *Newsletter* from The Blood Care Foundation

Dear Member,

Most people immediately associate travel to the tropics with malaria and possibly HIV. In this, my 27th newsletter, I describe some of the other common illnesses, which lurk in these areas, as well as highlighting the controversy around the so-called "Economy Class Syndrome".

Ebola Virus

By the end of October 165 cases of Ebola haemorrhagic fever had been reported in the Gulu district of Uganda, resulting in 60 deaths. This is the first known outbreak in Uganda, but the Gulu district is particularly vulnerable as it is so densely populated and has nearly half a million refugees living in squalid conditions. There is no vaccine available and the natural reservoir of the virus is unknown. Greg Hartl from WHO stated that this was the middle of the first wave but there could be another 3 or 4 to follow. (*BMJ*. 2000;**321**:1037**)**

Dengue Fever

Although most cases of dengue occur in Southeast Asia, the incidence has dramatically increased in Africa in the past 15years and is also a major problem in Central and South America. Also known as "Breakbone Fever", dengue typically presents as fever, headache, nausea, muscle and joint pain. The majority of cases resolve spontaneously and only require paracetamol, but patients should be monitored in case they develop the haemorrhagic version, a rare complication associated with previous infection. (*Travel Med. In Practice*. 2000;**2**:2-3)

Sleeping Sickness

For the first time in four years Trypanosomiasis has been reported in the UK. One case was in a man who had been on holiday to Zambia and the second was in a man who had been on safari in a game park in Tanzania. Both cases were of the acute form caused by *Trypanosoma brucei rhodesiense*, which is the form prevalent in east and southern Africa. In western and central Africa a more chronic disease is caused by *Trypanosoma brucei gambiense*. Dr Bertie Squires from the Liverpool School of Tropical Medicine believes that we could be seeing the beginning of a problem. He feels that the present civil unrest has led to a breakdown of the tsetse fly control measures leading to an upsurge in the disease.

HIV Post-exposure Prophylaxis

The DoH has recently published a revised guidance on HIV post-exposure prophylaxis. This covers health care workers seconded overseas and exposure outside the health care setting. Copies of the guidance can be obtained from Ms Ruth Hickson, Room 631B, Skipton House, 80 London Road, LONDON SE1 6LH or on www.doh.gov.uk/eaga.

Cabin Location and Seasickness

Most people believe that their liability to seasickness is increased if their cabin is not close to the centre of the ship. A recent study found that, whilst there was a definite correlation between age, sex and liability to motion sickness, there was no association with the location of the passenger cabin. (*J.Trav.Med.* 2000;**7**:120-4)

New Regulations for Ionising Radiation

New regulations controlling ionisation are to come into force on 13th May 2001. For the first time the doctor ordering an X-ray will have to justify his action and employers will be responsible for ensuring that a proper framework for radiation protection is in place. Failure to comply with the new regulations could lead to prosecution in the criminal courts for failure to discharge your duty under IR(ME)R 2000. For further information contact Ms Kathlyn Slack, Room 222, Wellington House, 133-155 Waterloo Road, LONDON SE1 8UG or www.doh.goc.uk/irmer.htm

Thrombosis and Air Travel

This problem recently hit the headlines after a young female collapsed and died from a pulmonary embolism shortly after disembarking from a flight from Sydney, where she had been attending the Olympic Games. A couple of weeks previously researchers from the Netherlands and Italy published the results of a survey of nearly 800 patients with suspected deep vein thrombosis (DVT). They found no difference in the incidence of DVT in those who had made a long-haul flight when compared with a control group. They concluded that long journeys did not increase the risk of DVT. (*Lancet*. 2000;**356**:1492) This contradicted the long held belief in the "economy class syndrome", which is excellently reviewed by Giangrande. He points out that the association of DVT with immobility is not confined to air travel and quotes studies in which the association has been noted in conjunction with long car, bus and train journeys. He also refers to the seminal article by Keith Simpson, who described DVT occurring in those people taking shelter from the blitz in the London Underground and who slept in deck chairs. (*J.Trav.Med.* 2000;**7(3)**:149-54) Since the publication of the original article, the Lancet has published a further article implicating reduced cabin air pressure as the primary cause of DVT. (*Lancet*. 2000;**356**:1657-8)

Longer Needles are Better

In my last newsletter I referred to an article in the BMJ showing that longer needles were more effective when giving vaccinations. In a more recent number of the journal, Dr Jane Zukerman has written an editorial emphasising the importance of using a sufficiently long needle. She points out that the immunogenicity of a vaccine is maximised by using the intramuscular route and, in addition, this route minimises the chance of an adverse reaction. Injecting a vaccine into subcutaneous fat , where there is poor vascularity, can cause failure. This is especially true of hepatitis B, influenza and rabies vaccines. (*BMJ*. 2000;**321**:1237-8)

Cold Can Burn

Most sportsmen are aware that an ice pack can reduce pain and swelling following soft tissue injury. However, many do not realise that if it is left in place too long serious frostbite can be the result. A recent article describes the case of a PE teacher who fell asleep with a bag of frozen chips on her painful foot. She awoke 40 minutes later to find that the pain had gone but the resultant ulcer, which extended down to the extensor tendons, required a split skin graft to heal it. (*Brit.J.Sports.Med.* 2000;**34**:382-4)

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