# An Occasional Medical Newsletter
# from The Blood Care Foundation

Dear Member,

Welcome to the seventh of my occasional series of newsletters.

**Malaria**

New guidelines for the prevention of malaria in travellers from the United Kingdom (UK) were published on 19 September'. Because of the importance of this problem, I am quoting directly from the CMO's Update 16 dated November 1997.

"The updated guidelines contain a detailed discussion of the issues that surround the choice of an appropriate antimalarial agent. This section, and the general sections about prevention of malaria, should be read carefully by all those who advise travellers.

Since the previous guidelines were published in 1995[2], growing awareness of, and publicity about, adverse neuropsychiatric reactions possibly related to the use of the antimalarial mefloquine ('Lariam') have made decisions about the choice of antimalarial drugs more difficult for some destinations. While all antimalarial agents are associated with adverse reactions in a proportion of travellers, it does appear that the effects associated with mefloquine are more likely to be distressing to the individual and to interfere with the purpose for which travel was undertaken. These guidelines recommend greater caution in its use, unless there is a high risk of highly chloroquine-resistant malaria. In practice, this means considering carefully whether to use chloroquine plus proguanil, rather than mefloquine, for short visits to places where the risk of highly resistant malaria is moderate, such as east African coastal resorts and visits to the Gambia during the dry season (January to May). However, such a change will be associated with an increased risk of malaria, and it is essential that travellers with a fever or flu-like illness within three months of being in a malarious area seek immediate medical advice. The guidelines also recommend that mefloquine prophylaxis, if used, is started two and a half weeks before departure - so that there is time to change to another antimalarial should an adverse reaction be experienced before leaving the UK, and to allow drug levels to reach more protective levels before exposure to malarial risk.

In Thailand, the malaria risk, though present, is low over much of the country so that it may be appropriate for travellers not to take an antimalarial, but to observe general precautions against mosquito bites, and to be aware of the risk and seek medical attention urgently in the event of fever. However, this advice does not apply to border areas where multiresistant falciparum malaria exists and doxycycline is now the drug recommended in the guidelines, although it is not licensed for this purpose.

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1. Bradley DJ, Warhurst DC, on behalf of an expert group of doctors, nurses and pharmacists. Guidelines for the prevention of malaria in travellers from the United Kingdom. *Commun Dis Rep CDR Rev* 1997; 7: R137-52.
2. Bradley DJ, Warhurst DC, on behalf of a meeting convened by the Malaria Reference Laboratory. Malaria prophylaxis: guidelines for travellers from Britain. *BMJ* 1995; 310: 709-14."


A recent survey of drugs brought from pharmacies and other outlets in Nigeria and Thailand found that, in both countries, the level of active ingredients was well below the British pharmacopoeial limits. This was especially true for chloroquine and a number of antibiotics. In six cases the

preparations contained no active ingredients at all. (*Tropical Medicine and International Health.* 1997;**2**:839-45)

**Lassa Fever**

Outbreaks of Lassa Fever continue to occur in Nigeria. Because even simple barrier techniques are not used in primary and secondary health centres, a recent survey discovered that, of 552 health workers screened, 12.3% had antibodies to the Lassa virus. (*Transactions of the Royal Society of Tropical Medicine and Hygiene.* 1997;**91**:379-81)

**CJD and Blood Donors**

The National Blood Data Resource Center in the USA has been investigating the possible transmission of CJD from infected donors to recipients of blood products. They have investigated 14 donors who subsequently developed CJD. In all, products from these donors were transfused into 180 recipients, none of whom have contracted CJD. (*AABB News Briefs.* August 1997;17)

In August, the Subcommittee on Human Resources and Intergovernmental Relations of the US House of Representatives held a meeting with the Public Health Service to discuss CJD. Dr David Satcher, director of the CDC stated "The risk of transmission of CJD by blood and blood products is extremely small, if it exists at all." Dr Paul Brown from NIH, one of the world's leading authorities on CJD, told the committee that he had been unable to infect rodents by blood transfusion. All the experts agreed that, whilst transmission of CJD by blood is a theoretical possibility, the number of infectious particles in the blood is so low that the only possible risk would be from pools of plasma used for the production of clotting factors and not from individual blood transfusions. (*AABB News Briefs.* September 1997;2)

Transmission of CJD, other than by direct intracerebral inoculation, is difficult and complicated. It appears that the abnormal prions have to integrate with the membrane proteins of B cells before they can multiply. The prions are then released and possibly travel up the peripheral nerves before gaining access to the brain. (Personal notes from a lecture by Dr Adriano Aguzzi at the meeting of the International Society of Blood Transfusion held in Frankfurt, 1st – 4th October 1997)

**Schistosomiasis**

A novel presenting symptom for Schistosomiasis has recently been reported by McKenna and colleagues. During the past three years, seven of nineteen travellers recently returning to Christchurch, New Zealand, who were diagnosed as suffering from *Schistosoma haematobium*, had presented to the sexual health clinic. Their presenting symptom was change in their seminal ejaculate. These alterations included change to a yellow colour, reduction in volume and change to a water-like viscosity. All of the men had swum in Lake Malawi, one of whom had only swum for a few hours at the water's edge. None had suffered from cercarial itch, but this would be in keeping with the concept that previous sensitisation is required before the itch occurs. Of the three female partners examined, two were positive for *S.haematobium* on serological testing. A high index of suspicion should be maintained for any traveller who has visited an area endemic for Schistosomiasis and who subsequently complains of an alteration in ejaculate. (***BMJ***. 1997;**315**:1000-1)

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