The Australasian College of Tropical Medicine
Faculty of Travel Medicine
in association with the New Zealand Society of Travel Medicine

Travel Medicine Briefcase

AUSTRALASIAN COLLEGE OF TROPICAL MEDICINE

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A historical look at travel medicine through the 90's

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Looking back at the 90's an enormous amount has changed in the field of travel medicine. I will briefly look at the changes that have occurred in the vaccine arena and have a brief look at some of the drugs relating to malaria.

In 1990 we did not have many of the vaccines that are available to us today, some were very restricted in their access, such as the Japanese Encephalitis vaccine and we did not have combination vaccines.

Great advances have occurred in the area of Hepatitis vaccination. In the early 90's we had a good Hepatitis B vaccine but none for Hepatitis A. All we could offer was immunoglobulin. People were put off when told it was a blood product and people who were going to live in endemic areas for years were not impressed with the idea of having immunoglobulin injections every six months and indeed many did not. I personally know of a death and a second person who only lived after a liver transplant having contracted Hepatitis A as expatriates. The introduction in 1994 of a safe synthetic Hepatitis A vaccine was a big step forward for travel medicine. Mass vaccination campaigns ensued. Later in the 90's the regime changed from a three injection to a two injection regime and one manufacturer produced a combined Hepatitis A and B vaccine–three jabs instead of 5! On a practical footing this created some problems explaining that a combined Hepatitis A and B vaccine could be given from one year of age but the Hepatitis A alone is only registered for two years of age upwards. In the late 90's introduction of Hepatitis B into the childhood vaccination program created more difficulties for young travellers as many having already had the Hepatitis B component had to wait until age two for the Hepatitis A alone vaccine.

1994 also saw the introduction of the purified capsular polysaccharide vaccine for typhoid. This one dose vaccine with fewer side-effects compared with the older two dose vaccine was another great advancement. The oral typhoid vaccine which had been available from the late 80's was hampered by poor compliance, although many would say that this did not alter its effectiveness. Debate also continued regarding three capsules vs four and how often re-vaccination should take place. The removal of the older killed typhoid vaccine unfortunately meant that vaccination of children under the age of two years was no longer available.

The 90's also produced some competition in the vaccine market with a second Meningococcal meningitis vaccine, choices of manufacturers for Hepatitis A vaccine, and a second manufacturer typhoid vaccine.

With the outbreak of Japanese Encephalitis in Torres Strait in 1995 we saw the full registration of the Je-Vax in Australia. Prior to this it was only available to a select group of clinics and many potential travellers were put off by having to sign disclaimers.

The 90's also saw severe shortages of Human Rabies immunoglobulin worldwide.

The late 90's saw the introduction of the chicken pox vaccine into the Australian market. Whilst many may not think this to be to relevant to travel I can assure you that a number of expatriates who have previously eluded the disease manage to contract Chicken pox whilst abroad.

There has not been much change in the TB arena except for a widening approach to only vaccinate the under five year old traveller proceeding on to an endemic area. Obviously, screening remains critical in the surveillance of TB in travellers and expatriates.

With a vaccine providing only partial protection for a short period everyone was eager to hear of the new oral cholera vaccine. However, the short term protective effect of the new vaccine with some strains left uncovered meant a smaller than expected uptake.

We continue to hear of research into Dengue and Malaria vaccines but to date nothing has emerged on the commercial front for these two diseases.

In the area of malaria two drugs have been largely abandoned. Maloprim usage continued to decline until it was taken off the market in Australia. This was largely due to newer drugs gaining favour and the side effect of agranulocytosis. Halofantrine also lost favour in the treatment of Malaria due to cardiac related deaths.

The introduction of Malarone onto the market provided a very effective and safe drug which could be used for treatment including standby treatment of malaria. Studies also showed it to be a very effective drug for chemoprophylaxis and one which could be stopped shortly after exit from malarious areas, a great benefit to compliance. To date it is not registered in Australia for this purpose and its other major drawback is cost. Many other drugs such as Azithromycin, primaquine and etaquine also have their stories relating to malaria but space limits this discussion at the present time. One area that still remains problematic is the long term prophylaxis for expatriates living in malarious areas. The reality is that very very few take medications long term but the flip side of the equation is that we have little to offer compared to the short term protective regimes of doxycycline or mefloquine.

This brief account only touches the tip of the iceberg of changes in the travel medicine field in the last decade but hopefully will inspire others to write about their views on various aspects of the subject.

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Editorial...

Welcome to another issue of the *Travel Medicine Briefcase*, a special regular supplement to the *ACTM Bulletin*. It is an Official Publication of the Faculty of Travel Medicine of the College and supported also by the New Zealand Society of Travel Medicine (NZSTM).

In this issue, we are featured an historical review of travel medicine development during the 1990's by Dr Mathew Klein. Mathew was recently appointed to take on the role of Chair of the Faculty of Travel Medicine, and I am sure we will give him every support in his new role. More on Dr Klein in a future issue.

I am also pleased to reproduce the Faculty's first Consensus Statement, which was recently approved by the College Council. It concerns the travel industry and we certainly welcome any further comments or feedback you may have. Consensus statements are not static documents and obviously evolve with time and changing circumstances.

I trust that you will enjoy this issue of the *Travel Medicine Briefcase*. It will continue to feature special articles and news on travel medicine from both the Faculty and the NZSTM. Your contributions and suggestions are most welcome via email.

PETER A LEGGAT
EDITOR–TRAVEL MEDICINE BRIEFCASE

AN APPLICATION FORM FOR THE FTM IS AVAILABLE ONLINE AT www.tropmed.org

Faculty of Travel Medicine

Consensus Statement Australian Travel Industry

(Approved by the College Council on 27 November 2001)

With an aim of optimising traveller's health the Faculty of Travel Medicine (Australasian College of Tropical Medicine) recommends that the Australian Travel Industry advise prospective travellers of the following issues.

- Many travel destinations have associated health risks. For some destinations vaccinations are required for entry and for many medical professionals would recommend specific vaccinations. Some destinations pose a risk of malaria and/or other mosquito borne illnesses and many pose food and water borne disease risks. Risks associated with accidents and trauma also exist as well as risks associated with casual sex and drug use.
- Travel also effects many ongoing medical problems as well as pregnancy.
- Travellers are strongly urged to seek the advice of a travel health professional or medical practitioner as soon as possible after planning travel abroad.
- The Travel Industry should also recommend strongly that travellers take out adequate travel insurance which includes a medical component.

CONFERENCE REPORT: MSD Travel Medicine Update, Wellington, New Zealand

This was held in Wellington on 1 December 2001, World AIDS Awareness Day, with good attendance from nurses and doctors throughout New Zealand (NZ). The Official Welcome was done by Maureen Dawson MSD Vaccines NZ Manager. Dr Nigel Raymond, Infectious Diseases specialist from Wellington, gave an overview of HIV and the Traveller. NZ has 100 new cases /year with 50 deaths. Treatment for needle stick injuries and use of vaccines was discussed. Dr Raymond also gave a discussion of Bio Terrorism with the threat of Smallpox and Anthrax.

Dr Jenny Visser gave a presentation on her travels to Antarctica as a medical support person with medical conditions planned for and encountered, plus some wonderful views on the way. Cold immersion suits were also demonstrated.

A Travellers' Thrombosis study by Sarah Hill is underway in New Zealand with results from previous studies and in New Zealand thus far. Use of compression stockings and heparin for prevention in high risk travellers was discussed.

Wendy Penno also gave an update on Polio vaccine with the change to injectable form from Oral in new year. Cost will be about $30 / injection. Eradication of Polio is hoped for 2005 worldwide.

Eunice Borrie MSD representative gave a review of Hepatitis B screening for travellers and overview of impact of Terrorism on travel.

A lovely meal was enjoyed at the Whitehouse with fellowship from the various participants. The following day a display on vaccines, Travel Medicine and Health record by Dr Global was held at Te Papa in conjunction with the Body Odyssey exhibit sponsored by MSD.

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