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Health Disparities While "Visiting Friends and Relatives"

In 2005-2006, thousands of foreign-borne U.S. residents stated that, "visiting relatives and friends", (VRF) was their main purpose for travel. This population shows higher disparities in the number of reported cases of preventable travel-related illnesses when compared to those traveling for business or pleasure. The majority of these illnesses could easily be prevented with proper vaccines for common childhood diseases like measles, mumps, rubella, tetanus and diphtheria, and polio as well as hepatitis A and B. Additional health risks like malaria, meningitis, yellow fever and typhoid fever, depending on the travel destination, can be prevented with vaccine and/or medications.

Although global travel and migration have long been recognized as key contributors to the transmission of infectious disease, the prevention of illness for those traveling back and forth from their homeland is minimal. More than half of U.S. foreign-borne residents are from Latin America, while 25% originated in Asia and a growing number come from countries in Africa. VRF's are frequently visiting their country of origin with an increased level of poverty which have challenged regulatory systems regarding water and sanitation. VRF's often stay for much longer periods of time than the average business or leisure traveler and on occasion, in areas without window screens or mosquito bed nets. Foods are not always properly cooked for safety and treated water is a rarity.

In one study conducted in Houston, Texas, Nigerian VRF participants were asked about their perception of malaria. Although the respondents believed that they were susceptible, they did not consider malaria as a severe illness. Malaria was described as "expected", "flu-like", and "normal". However, according to the World Health Organization (WHO), malaria accounts for 3,000 deaths in Nigeria every year. The problem is so prevalent that WHO has initiated a program called "Roll Back Malaria" in an attempt to reduce morbidity and mortality rates.

The World Health Organization (WHO) has announced a disturbing increase in the number of cases of polio since 2003, due largely to a boycott of the polio vaccine in Nigeria in that same year. To date, this wild polio virus has spread throughout Africa, been identified in Saudi Arabia and Yemen and into Southeast Asia to include 26 countries with confirmed cases of polio paralysis.

In order to affect a positive change in these disparities, adequate immunization and food and water precautions is of the utmost importance to the VFR group. Due to the nature of their journey, these health issues are often more critical than with any other types of travelers. If you are in the "visiting family and friends" group, remember to visit your travel health specialist at Passport Health to protect yourself and your family against these preventable diseases.

Pertussis (Whooping Cough) is on the Rise

Since 1980, there has been an increase in the number of cases of pertussis (whooping cough) in the United States. Pertussis is a highly contagious bacterial infection that causes coughing with little or no fever. Coughing may result in vomiting or gagging. Some infected persons make a "whoop" sound when they breathe in after coughing.

In the year 2004, there were 25,827 reported cases of pertussis in the U.S. Of these cases, 34% were in the age group 11-18 years while 29% were in ages 19 years through adulthood. Between the years 2000 – 2004, there were 100 deaths from pertussis in infants less than 4 months of age.

Infants less than 12 months of age are more likely to have severe complications and be hospitalized from pertussis than any other age group. These complications may include pneumonia, convulsions, brain damage and death. Infants are at greater risk due to the lack of immunity from incomplete vaccination while, most often, being exposed to an infected family member.

In the spring of 2005, two tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine **(Tdap)** products were licensed in the United States; Adacel (Sanofi Pertussis) approved for **ages 11-64 years** and Boostrix (GSK) approved for ages 10-18 years. In June 2005, the Advisory Committee on Immunization Practices (ACIP) voted to recommend routine use of Tdap for adolescents 11-18 years and adults to replace tetanus/ ▶ *2*

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New Drugs Offer New Hope

In May 2006, The Food and Drug Administration (FDA) licensed a new vaccine, **Zostavax** (Merck), to reduce the risk of shingles (herpes zoster) for use in people **60 years of age and older**.

Shingles is a disease caused by the varicella-zoster virus, the same virus that causes chickenpox. It can occur in people of all ages but is most common in those 60 years of age and older. Shingles is estimated to affect 2 out of 10 people in their lifetime with an estimated 1 million cases occurring each year in the United States.

Shingles is characterized by numbness, itching or severe pain, followed by clusters of blister-like lesions which develop on one side of the body and can cause severe pain that may last for weeks, months, or years after the rash has healed. This pain is known as post-herpetic neuralgia (PHN). For some people, this pain can be severe and chronic.

Shingles is contagious to persons who have not had chickenpox so caution should be taken for those individuals so they do not potentially develop chickenpox. You cannot catch shingles itself from someone who has shingles.

Zostavax vaccine is given as a single dose injection in the upper arm. The vaccine effect is highest at 64% in the 60-69 age group and has an overall effectiveness rate of 50% when including all age groups (age 60 years and above). For those who are vaccinated with Zostavax and still develop the disease, the incidence and severity of PHN was reduced.

In June 2006, the Food and Drug Administration (FDA), approved **Gardasil** (Merck), the first vaccine designed to protect against human papillomavirus virus (HPV), the most common sexually transmitted infection in the United States. Gardasil was developed to prevent cervical cancer, precancerous genital lesions, and genital warts due to HPV. The FDA evaluated and approved Gardasil in 6 months under FDA's priority review process-a process for products with potential to provide significant health benefits.

An HPV infection cause virtually all cases of cervical cancer and is the second most common cause of death from cancer among women worldwide. It is estimated that more than 20 million men and women in the United States are currently infected with HPV and there are 6.2 million new infections annually and 3700 deaths each year in the United States. Worldwide, there are an estimated 470,000 new cases each year with 233,000 deaths from cervical cancer related to HPV infections. HPV is most common in sexually active young men and women in their late teens and early 20's but by age 50, 80% of women will have acquired HPV infection.

The Advisory Committee on Immunization Practices (ACIP) voted to recommend that this newly licensed vaccine be **routinely given to girls when they are 11-12 years old**. Gardasil is currently approved for use in females 9 to 26 years of age. The vaccine should be administered before onset of sexual activity but females who are sexually active should still be vaccinated. Gardasil is administered in a series of three injections over a six-month period with the initial dose, the second at 2 months and the third dose at 6 months.

Although this vaccine is a major advance in the prevention of genital HPV and cervical cancer, it does not replace other preventive strategies such as cervical cancer screening or protective sexual behaviors. Women should continue to get pap tests on a regular basis as part of an overall wellness plan.

Passport Health will be offering Zostavax and Gardasil as part of their comprehensive line of vaccines. Please check your local Passport Health office for availability and additional information. ■

Whooping Cough

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diphtheria (T/d) boosters to reduce the morbidity in adolescents, reduce the morbidity and mortality in exposed younger siblings, and maintain standards of care for tetanus, diphtheria and pertussis protection. The preferred age for adolescent vaccination is 11-12 years of age (time between completed childhood vaccine series and recommended booster).

For travelers, pertussis occurs worldwide and rates are highest among young children in countries where vaccination coverage is low. Immunity from childhood vaccinations as well as from natural disease, wanes between 5 to 10 years leaving adolescents and adults vulnerable. Diphtheria also remains a serious threat throughout the world. Areas of known endemic diphtheria include Africa, South and Central America, Asia and the South Pacific, the Middle East and Albania, and all countries of the former Soviet Union. Tetanus is a global health problem because the C. tetanus spores are ubiquitous. The disease occurs almost exclusively in persons who are inadequately immunized. It is important that travelers to underdeveloped countries consider being boosted with Tdap prior to departure if it has been more than two years since their last tetanus booster. ■

Health Disparities

Heleneve Parks is teaching in China for a year. The following is an excerpt from one of her emails with recommendations for face masks related to local air quality conditions:

Every day there is a lot of dust. Rain is so welcome because it clears the air. Plus Jinan is a highly industrialized city with heavy road and building construction underway at all times. That creates industrial pollution as well as additional dust. The usual breeze/wind is a mixed blessing since it does cool the air, but it also plasters every surface and opening with grit - surfaces like skin and clothes, openings like eyes and nose. Now you can see why the masks you sent are life-savers to me. I think anyone traveling anywhere in China except maybe the tropical southern areas would be well advised to take some masks. I have read that the dust is blown across China from the western and Mongolian deserts. That's a lot of dust.
Thanks again for the masks.

Hurricane Wilma was the most intense hurricane ever recorded in the Atlantic basin. In October 2005, this category 5 hurricane devastated parts of the Yucatan Peninsula and southern Florida. The following is one client's account of his experience while in Mexico during hurricane Wilma:

My last post from Cozumel indicated I had been beached after three days of beautiful diving because of a little storm that was cooking down around Honduras. Well, that little storm turned out to be Wilma, the worst storm to ever hit the island. I could write volumes on what happened over the last week, but this message will be as short as possible to give you a flavor of what happened, and some lessons learned. The really short version; Cozumel and Cancun are disaster areas.

We arrived in Cozumel on Saturday, 10/15/05. I did a weather search before leaving and no obvious dangers were evident. On Wednesday, when we showed up to dive, we were told there was a "little storm" coming toward the Island, and that there would be no diving because the harbor master closed the port. The weather and water conditions were still gorgeous.

When we arrived back at the hotel, we discovered that Wilma was a Category 5 hurricane headed straight for us. I called our air carrier but they had no available seats. The hotel had nailed sheets of plywood over the windows, placed lounge chair cushions with pillows and blankets on the floors, had food and water available, and claimed to have an emergency generator. That evening we got "locked down" for the duration. During the worst part of the storm it was obvious that the storm preparations were inadequate. We had to have shifts of 4 to 5 men constantly push against the barricade to keep the storm at bay. The power failed and the emergency generator failed. The winds were 150 MPH plus, we slept when we could, ate and drank water, took turns manning the barricades and mopping/bailing up the water that was coming in faster than we could control it. On Sunday, following 3 days of lock down, we were allowed to return to our rooms. It was still a bit windy to go outside and there was no power or running water. We had no communications with the outside world. A survey of the surrounding area revealed widespread destruction and we felt fortunate to have survived the ordeal. Lessons I have learned:

1. Have a cell phone with international capability. Had I had mine reprogrammed before I left the States I would have had information, communications, and the ability to have someone back in the States work the internet in my behalf. Make sure you bring a charger, and keep your phone fully charged.
2. Take a couple of good flashlights with fresh batteries.
3. Take enough medications to last a week more than you planned.
4. Take a first aid kit. You be the judge of what you'll need, but remember you just might get sick.
5. Try to pack everything in one checked suitcase per person. This may be hard because the new rule since October 1st is 50 lbs max instead of the previous 70 lbs, and diving gear weighs a bunch. The other diving gear option is to only take what you absolutely need, and rent the rest, but this depends on where you are going and what kind gear is available.
6. Don't take a lot of unnecessary valuables, always have your passport and valuables locked up or on your person, and never leave them unattended.
7. Place copies of your passport in your luggage, and leave one with a person back in the States that you can contact.
8. Notify your credit card folks of where and when you will be traveling so that they don't turn you off without notice because of some funny charges. That happened and almost cost some people a flight home.
9. Register your travel on-line with the State Department. This is real easy to do.
10. Have lots of one, five and twenty dollar bills. Traveler's checks aren't always taken, and if all you have are 50 and 100 dollar bills it might just cost you that amount for an inexpensive item or service.
11. Always take a good pair of walking shoes that completely incase your feet. After earthquakes and hurricanes glass and debris are very common.
12. Take along patience and a sense of humor, and try to help others whenever you can.

Wayne P.
Surf City SCUBA

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Passport Health
921 East Fort Avenue, Suite 100
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Q. I traveled to Africa for vacation and only 2 days after arriving I developed a fever, chills and joint pain. I treated the symptoms and did recover but was wondering if this could be Malaria?

A. Malaria is an acute febrile illness with incubation period of 7 days or longer. Thus, a febrile illness developing less than one week after the first possible exposure is not likely malaria. The most severe form is caused by *P. falciparum*, in which variable clinical features include fever, chills, headache, muscular aching and weakness, vomiting, cough, diarrhea and abdominal pain.

Q. What is the difference between Typhoid and Typhus Fever?

A. Typhoid Fever is an infection caused by contaminated food or water while Typhus Fever is transmitted by the human body louse, which becomes infected by feeding on the blood of patients with acute typhus fever. Infected lice excrete rickettsia onto the skin while feeding on a second host, who becomes infected by rubbing louse fecal matter or crushed lice onto the bite wound.

Q. I was on prophylaxis for malaria while in India on an assignment. I've returned and now want to become pregnant. Are there any precautions or recommended wait periods after taking mefloquine?

A. After you have been on mefloquine, you should delay pregnancy for 3 months. However, if pregnancy occurs during antimalarials prophylaxis with mefloquine or Doxycycline, this is not considered to be an indication for pregnancy termination.

Q. I am going to Central America to visit a cousin who lives there. She told me that she had Dengue Fever last year. Is she contagious?

A. Dengue is transmitted by the Aedes *aegypti* mosquito, which bites during daylight hours. There is no direct person-to-person transmission. Monkeys act as a reservoir host in South-East Asia and West Africa. Travelers should take precautions to avoid mosquito bites both during the day and at night in areas where dengue occurs.

Q. My company is sending me to several sites in East and Central Africa and they told me to be sure to get my Yellow Fever and meningitis vaccinations. Is there really a problem with meningitis in this area of the world?

A. Yes, between January and March 2006, there have been over 5,700 reported cases of meningitis with almost 600 deaths in the following countries; Burkina Faso, Cote d'Ivoire, Kenya, Mali, Niger, Sudan and Uganda.

Q. I've heard that Polio is a real problem in Namibia and I'm going on a mission trip there. Is this true?

A. Yes, during this year (2006) there have been 34 confirmed cases of "wild polio" in Namibia. If it has been more than five years since you completed your childhood polio vaccination series, you should receive a polio booster prior to taking your trip to Namibia, especially since you will be working closely with the local population doing your mission work.

Q. A bunch of my friends and I are about to do a summer vacation in Europe and want to know if there are any major health concerns we should be aware of before we travel?

A. There is a current serious outbreak of measles and/or mumps in many European countries including Germany, Denmark, Greece, Poland, Spain, Sweden, Ukraine, Wales and England. You should consider a MMR booster if you don't have a confirmed history of these diseases or have not completed your childhood series of vaccinations against measles, mumps and rubella. You also need a current tetanus/diphtheria vaccination but may want to consider being boosted with Tdap which combines pertussis along with the tetanus and diphtheria vaccines.