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Travel medicine: an American view of the Australian perspective

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Peter Leggat has beautifully and succinctly summarized many of the key issues in travel medicine. With humility, he claims only to have presented an Australian perspective. In fact, travel medicine is a growing global domain of medicine. Leggat’s description is appropriately multi-national in perspective, and most of it is true beyond the specific political boundaries surrounding a particular traveler’s place of origin.

Travelers with itineraries originating in developing countries might indeed have different risks and needs than the typical American or Australian traveler. Nonetheless, Leggat’s Australian perspective provides a good description of the North American perspective on most major points. Certainly, the need for good pre-travel consultation and intervention is similar between the two continents. Sadly, it is also similar that too many North American travelers do not seek and/or obtain adequate pre-travel input and intervention, and the results of incomplete preventive interventions can be devastating.\textsuperscript{1,2} Leggat’s discussions of immunization and malaria prevention are mostly applicable to American travel clinics as well.

Similarly, discussions of injury prevention, management of illness during travel, and insurance would also be part of a typical North American pre-travel consultation.

Despite the similarities, however, there are some noteworthy contrasts between Leggat’s Australian perspective and the typical North American view of travel medicine. Some of these relate to the medical system and the means of getting pre-travel care. Others relate to details of the care provided.

Systems of care for travelers

Much pre-travel care in Australia, it seems, is at the hands of general practitioners. In the United States, most generalists do not have ready access to some pre-travel vaccines (typhoid and Japanese encephalitis since they would not frequently be used in a typical primary care practice, yellow fever due to certification requirements), and most pre-travel care is provided in specialty clinics mostly staffed by infectious disease physicians.\textsuperscript{3} Trained, experienced nurses provide much of the pre-travel care in some of these clinics, and they use established protocols under physician guidance to make prescriptions for medications available to travellers.\textsuperscript{3} North American primary care providers not
specifically trained in travel medicine would be more likely to limit their travel medicine advice to travelers going to settings where vaccination beyond hepatitis A is not needed.

Leggat also points out that there are similarities between the practices and needs of aviation medicine and travel medicine. This is true, but the two fields remain separated in North America. Certification by a governmental agency (http://www.cami.jccbi.gov/) and complex documentation are required for physicians to officially evaluate a pilot’s fitness to fly, and it is uncommon for an individual physician to combine travel medicine and aviation medicine.

Leggat also describes integrated collaboration between travel medicine providers and the travel industry. This is logical and appropriate and good for travelers. Americans have much to learn from Australians on this point, and it is only in very recent years that initiatives, some through the International Society of Travel Medicine, have started to capitalize on this potential linkage in the United States.

American travel medicine practitioners are often affiliated with the International Society of Travel Medicine, as are their Australian counterparts. In addition, the American Committee on Clinical Tropical Medicine and Travelers, Health (http://www.astmh.org/subgroup/acctmth.asp) provides a forum for education, certification, networking, and communication for practitioners of travel medicine. The Centers for Disease Control and Prevention (CDC) (http://www.cdc.gov/travel/) also serves travel medicine providers as a high-quality resource for printed, electronic, and telephone information regarding pre-travel and post-travel care. In addition, the Infectious Disease Society of America is finalizing a statement of guidelines for the practice of travel medicine in North America which will likely be published in 2005.

The US government issues travel warnings (http://travel.state.gov/travel/warnings_current.html) which guide prospective travelers in regard to safety issues in potential destination areas. The CDC website also includes special alerts about noteworthy dangers during acute situations (http://www.cdc.gov/travel/). This ‘real-time’ information is vitally important and helpful during outbreaks such as that of Severe Acute Respiratory Syndrome in 2003.

Pre-travel interventions

As noted by Leggat, diarrheal illness is a common problem for travelers. Leggat does not discuss details of pre-travel counseling on this point, but most North American pre-travel consultations include a significant discussion of food and water hygiene as preventive interventions and of oral hydration and possibly loperamide as presumptive treatment. In addition, a prescription for an antibiotic to use in the event of bothersome travelers’ diarrhea is often provided. A quinolone or azithromycin would be the most likely antibiotic used in this setting.

In the United States, it is currently recommended that all infants and patients with chronic medical problems receive influenza vaccination, whether they are traveling or not. Similarly, pneumococcal vaccine is routinely given to infants and is recommended for older adults. Current recommendations for immunization of American children are updated regularly (accessible via http://www.aap.org/healthtopics/immunizations.cfm). A pre-travel consultation provides the opportunity to ensure that these routine vaccines have been given—even though they might not be routine in the destination country.

Hepatitis A vaccine is recommended for children in several American states, and it is used almost routinely for foreign travellers. There is also liberal use of typhoid vaccination for travelers to higher-risk countries.

Officially, there are three alternative malaria chemoprophylaxis possibilities for American travelers to areas of chloroquine-resistant malaria, but primaquine is also considered to be a potential option (http://www.cdc.gov/travel/malaria-drugs2.htm). With the ready availability and side effect profile of atovaquone-proguanil, however, many travel medicine clinics are increasingly prescribing this product as the mainstay of malaria protection. Concurrently, there is an emphasis on mosquito avoidance and the use of chemical repellents on exposed skin and insecticides on clothes and bednets. ‘Stand by’ malaria treatment is not commonly recommended in the United States, and rapid displacement to a site of good medical care is advised for a traveler who might have malaria.

Thus, Leggat’s perspective is representative of most of the American practice of travel medicine. Notable differences, however, center on the use of both infectious disease specialists and nurses in North American pre-travel consultations rather than primary care physicians and on the non-union of aviation medicine and travel medicine in the United States. Americans’ specific pre-travel interventions are also similar to those in Australia, but influenza, pneumococcal, and hepatitis A vaccines are used more widely for even at-home populations in the
United States. As similarities and differences are explored and documented, it is clear that while travel medicine is truly a global specialty, the specific risks and resources vary between sites, and these affect the details of a travel medicine practice.

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