

TIMELY ADVICE FOR THE LAST-MINUTE TRAVELLER

With the easy availability of online booking, last-minute travel is increasingly common. With careful thought, adequate advice on health risks and vaccinations can still be made available, as Mike Townsend explains.

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In the excitement of planning a trip abroad, health precautions are often the last consideration of the traveller. Late business trips and the easy availability of online booking of last-minute foreign holidays add to the problems of the travel health adviser faced with a traveller who is departing in a few days' time. Some travellers may have only a hazy idea of the geographical location of their destination, while health information is not usually very prominent or even accurate in their booking information. Is it then possible to give adequate advice and help to these travellers?

Risk assessment

Travel health advisers need to have some knowledge of the location, topography and climate of the countries to which their travellers are going. As well as medical books in the practice library, a good world atlas is invaluable. The length and nature of the proposed trip, the likely activities to be undertaken and the budget and type of accommodation to be used are all important factors in assessing the traveller's health risks and the precautions likely to be needed.

Connection to an online database such as Travax (www.travax.nhs.uk) is essential to assist in building up the individual risk assessment for each traveller, whatever the time-scale of his or her travel. For travellers with a vague itinerary, it is better to plan for the worst possible case scenario and act accordingly. For example, if there are different levels of malaria risk in different areas that might be visited, it is wise to prescribe prophylaxis that will cover the risk in the highest risk area and to prescribe the same

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antimalarial drug throughout the whole trip. Particularly in the case of backpackers and low-budget travellers, it is wise to assume that if there is a possibility of a health risk they should be protected against it wherever possible. Other high-risk groups are those likely to be living and mixing at close quarters with indigenous people in developing countries and sharing similar standards of food, water, infrastructure and accommodation to which package tourists are not normally exposed.

Vaccinations

Vaccines may take up to 2 weeks to provide optimum levels of protection, though reinforcing ('booster') doses following an earlier primary vaccination become effective more rapidly. For this reason, it is worth giving reinforcing doses of vaccines in the UK child immunisation schedule, such as tetanus and diphtheria, (if indicated), to last-minute travellers.

The decision on whether to offer vaccination to last-minute travellers will depend on a number of considerations:

Length of trip

For very short trips the traveller may be on their way home before the vaccination has become fully effective, though some measure of protection may be obtained. However, for longer stays abroad, necessary vaccinations should still be given even though the early days may be less well protected. It will be necessary for the GP to weigh up the level of risk against the length of the trip and the speed of onset of protection.

TABLE 1: VACCINES WITH A SINGLE-DOSE PRIMARY COURSE

These vaccines do not present any scheduling problems for the last-minute traveller

Vaccine	Interval to next reinforcing dose
■ Hepatitis A	6–12 months, then 10+ years
■ Meningococcal ACWY conjugate vaccine*	Probably more than the 5 years stated for the older polysaccharide vaccine
■ Typhoid	3 years
■ Yellow fever	10 years*

* Single dose if aged over 1 year; Menveo brand, 2 doses at intervals of 1 month from age 3 months to 1 year

TABLE 2: VACCINES WITH A MULTIDOSE PRIMARY COURSE: ACCELERATED SCHEDULES

These schedules are not to be confused with the normal schedules, which should be used whenever the traveller presents sufficiently early. Some accelerated schedules require a reinforcing (booster) dose earlier than is the case after a normal schedule, after which the normal intervals for reinforcing doses are resumed

Vaccine	Accelerated schedule	Interval to reinforcing dose
■ Hepatitis B	0, 1 and 2 months OR 0, 7 and 21 days	1 year, then at 5 years subsequently
■ Japanese encephalitis	0, 7 and 14 days	2–3 years
■ Rabies	0, 7 and 14 days	2–5 years
■ Tick-borne encephalitis	0, 7 and 21 days	12–18 months, then at 3 years subsequently

Level of risk

Vaccination should always be subject to an individual risk assessment. The last-minute traveller is no exception. For example, a backpacker going to India is at much higher risk from typhoid than a business traveller staying in five-star hotels, and the backpacker's trip is likely to be longer. Thus, the backpacker should still be vaccinated against typhoid even if he intends to travel tomorrow, whereas business travellers are less likely to be exposed to typhoid and, if their trip is relatively short, the balance is probably against giving the vaccine.

Yellow fever vaccination

Yellow fever is the only vaccination for which a vaccination certificate is statutorily required for entry to some countries. Even if a certificate is not an entry requirement, it is important that travellers exposed to a risk of yellow fever should be protected as the disease carries a high mortality rate. Protection will be incomplete, and the certificate does not become effective, until 10 days after vaccination, so entry is likely to be refused within that period if it is a statutory requirement.

Multidose primary courses (see Table 2)

Some vaccines, such as hepatitis B, may be given in an accelerated schedule, e.g. 0, 1 and 2 months or even 0, 7 and 21 days instead of 0, 1 and 6 months (Table 2), but even this schedule may be too long for the last-minute traveller to complete. Initial doses of such a course will confer some degree of immunity while subsequent doses are intended to maintain this immunity for a longer period. For a relatively short-stay traveller, it may

If the picture remains unclear, it is important to consider other diagnoses

therefore be advisable to give as many doses as possible, even if this is only one dose. The course can then be completed on the traveller's return against the possibility of future exposure to risk, and a primary course can be resumed where it was left off. If the usual schedule is interrupted, it is not necessary to start a primary course again from the beginning. For longer stays it may be possible, depending on the destination, to arrange to have the course completed during travel.

Other precautions

Vaccinations are not the only way of preventing infection. Attention to food, water and personal hygiene, avoidance of insect bites and safe sexual practices will help to protect against many travel-related infections. Leaflets on these topics will help to reduce the amount of verbal information given (and probably forgotten) in what is likely to be a rushed last-minute consultation.

Malarial prophylaxis

Antimalarial drugs need to be started before travel. Chloroquine and proguanil must be started a week prior to exposure to risk. Mefloquine should be started 3 weeks prior to exposure, as its adverse effects are most likely to

TABLE 3: ANTIMALARIAL DRUGS

Drug	Pre-exposure	Post-exposure	Relative cost
■ Chloroquine and proguanil	1 week	4 weeks	£
■ Mefloquine	3 weeks	4 weeks	££
■ Malarone (atovaquone + proguanil)	1–2 days	1 week	£££
■ Doxycycline	1–2 days	4 weeks	£

Necessary vaccinations should still be given even though the early days may be less well protected

be observed in the first 3 weeks; an alternative drug can be chosen, if it proves unsuitable. However, this makes mefloquine less suitable for last-minute travellers.

Very last-minute travellers may use Malarone (atovaquone/proguanil), which can be started 1–2 days prior to exposure, though it is more expensive, and budget travellers may be reluctant to take it. Doxycycline should also be started 1–2 days before exposure and is less expensive. (see Table 3).

If the traveller is going to a high-risk area, it is advisable to start prophylaxis with an appropriate drug, even if the initial period prior to exposure cannot be observed, rather than not taking the drug at all.

Travellers still need to take appropriate anti-bite precautions whatever the situation regarding medication. If they are likely to be exposed to infections transmitted by daytime-biting mosquitoes, such as dengue, they need to observe these precautions during the day as well as between dusk and dawn. Although chemoprophylaxis will still be necessary, the risk of malaria can be reduced by anti-bite precautions, e.g:

- Effective insect repellents containing DEET (N, N-diethyl-m-toluamide)
- Covering as much skin as possible with clothing
- Sleeping under a bed-net impregnated with permethrin will reduce the risk of malaria but will not eliminate the need for chemoprophylaxis
- Again leaflets on bite avoidance will be useful to save time in the consultation.

Non-vaccine preventable diseases

Time is likely to be at a premium at the last-minute travel consultation. However, these travellers still need advice about health risks, such as food and water, heat, sunlight, accidents, insect bites, etc. The travel health adviser should have a series of leaflets available covering non-vaccine preventable health risks.

Avoiding last-minute problems

It is better to avoid last-minute problems than to have to try to cope with them. Some of the ways in which this could be achieved include:

- Promote your travel health service. Posters in the waiting room encouraging travellers to present early for advice will help. If you operate a travel clinic, it may be worthwhile asking travel agents to draw clients' attention to the services you offer
- Ask your local NHS administrative body to list practices operating a travel service in their local directory
- Enquire routinely about travel plans when patients present for other reasons
- Operate an effective recall system for primary course and reinforcing doses of vaccines
- Contact local employers who regularly send employees abroad with information about the importance of travel health precautions. Ask employers to encourage employees to present as early as possible before travel.

KEY POINTS

- 1 An individual risk assessment is needed for all travellers
- 2 Give all necessary vaccinations, even if the full course cannot be completed before travel. Some protection is better than none
- 3 A yellow fever vaccination certificate is not acceptable for entry into any country requiring a certificate until 10 days after vaccination
- 4 Use accelerated vaccination schedules where appropriate
- 5 Choose antimalarial chemoprophylaxis appropriate to the highest level of risk likely to be encountered
- 6 Give advice and leaflets on other methods of avoiding health hazards

ONLINE RESOURCES

- Travax travel health database: www.travax.nhs.uk
- Fit for Travel: www.fitfortravel.nhs.uk
- The National Travel Health Network and Centre: www.nathnc.org
- The British Global and Travel Health Association: www.bgtha.org
- The International Association for Medical Assistance to Travellers (IAMAT): www.iamat.org