

Unwanted Souvenirs Can Plague World Travelers

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SAN FRANCISCO — Adventure tourists, international volunteers, and people visiting their families in the Third World are the travelers most likely to bring home unwanted souvenirs, from malaria to schistosomiasis.

"You're not going to see these things in businessmen who are staying in Hiltons and eating Western food when they go overseas," Dr. Sukhjit Takhar said at the 12th International Conference on Emergency Medicine. "These are diseases people contract when they are traveling for longer than a couple of weeks, or when they are really getting immersed in the local culture or eating the local food."

Taking a good travel history is the first step in diagnosing an internationally acquired disease, said Dr. Takhar, an emergency physician at the University of California San Francisco-Fresno.



cyclical, so up to 40% of patients will be afebrile when you see them in the ED," Dr. Takhar said.

Falciparum malaria is the most dangerous form, provoking a flulike illness followed by paroxysmal fevers that last 8-12 hours and culminate in a drenching sweat. After that, the patient may feel well. The less common vivax malaria is also a less serious illness but causes similar symptoms.

The time since onset of symptoms is a clue to the type of malaria, Dr. Takhar said. The incubation period for falciparum malaria is about 10-14 days, while that of vivax malaria may be longer.

A blood smear will diagnose either form, with the parasites appearing in the erythrocytes. If the index of suspicion for malaria is high, however, and the patient reports travel to endemic areas, consider treating presumptively, Dr. Takhar advised. "They can look well and then decompensate very quickly, so don't wait around for a

DR. TAKHAR

consult from a specialist."

The treatment of choice in the United States is now quinidine. "Chloroquines don't work very well any more, because the parasites have become resistant," he said, and the most potent antimalarial, artemether—an extract of the wormwood plant—isn't readily available in the United States.

A negative smear doesn't eliminate the possibility of malaria. "You can have a negative smear and still have it. The patient might have taken some doxycycline or azithromycin when he started feeling bad. Both of these have some antimalarial properties," he said. "If you don't see the parasites, get another smear in 12-24 hours."

A negative malaria smear in a febrile patient with a low white blood cell count, thrombocytopenia, and recent travel to the tropics may point to another mosquito-borne illness: dengue fever.

Diagnosing Dengue Fever

The prevalence of dengue has grown dramatically in recent decades. It's now found in more than 100 countries in Africa, Central and South America, the Caribbean, Asia, Southeast Asia, and even around the Mediterranean.

"Travelers who don't protect themselves from mosquitoes in these areas will very likely come down with this illness," he said.

The dengue virus causes a severe flulike illness with high fever, headache, retro-orbital pain, and a myalgia so painful that dengue is nicknamed "breakbone fever," Dr. Takhar said.

While most cases are self-limiting and require only supportive care, the hemorrhagic form can be deadly. In addition to petechiae, patients may have plasma leakage leading to pleural effusion, dropping platelets, rising hematocrit, and ascites.

Again, treatment is supportive. "You need to give IV fluids, but because these patients leak plasma, you should also put in a central line to measure central venous pressure," he said. Don't give any aspirin or ibuprofen for the pain, because those agents can exacerbate bleeding.

Tick Bites and Flatworms

Rickettsial diseases are sometimes seen in those who travel to Africa during tick season (April-November). Fever, myalgia, and headache characterize the illnesses; an eschar at the site of the tick bite is another clue. Most rickettsial infections respond quickly to doxycycline.

African travelers who swam in lakes may bring home a load of schistosomes. These flatworms live in freshwater snails, which release the larvae into the water. The larvae burrow into a swimmer's skin and take up residence in the liver. After maturing (up to 10 mm long), the worms mate and move into the rectal and mesenteric veins, where they release their eggs. The eggs pass into the intestine, bladder, or rectum, and are excreted.

The worms live up to 4 years, so natives of endemic areas can have huge loads that create chronic disease. However, travelers usually come down with an acute case, called Katayama fever. Symptoms include abdominal pain, cough, diarrhea, eosinophilia, fever, fatigue, and hepatosplenomegaly. Early in the course, the patient may have urticaria and a rash where the larvae penetrated the skin.

Diagnosis is by fecal smear or urinalysis positive for the flatworm's eggs. Schistosomal antibodies can also be positive. Praziquantel is the usual treatment, Dr. Takhar said. It should probably be prescribed by an infectious disease specialist who can provide adequate follow-up. ■

Managing Malaria

Apart from acute diarrhea, systemic febrile illnesses are the most common syndromes among returning travelers. Most of those will be either malaria or dengue fever.

Among all travelers, 35% will have malaria, which causes about 150 fatalities in returned travelers each year; and 10% will have dengue. More than 60% of travelers with a systemic febrile illness coming from Africa will have malaria, Dr. Takhar added. About 30% of ill travelers returning from Southeast Asia will have dengue fever.

Because of the prevalence, morbidity, and mortality of malaria, especially that caused by the *Plasmodium falciparum* parasite, patients who appear to have the disease should receive immediate treatment, even if they don't present acutely ill to the ED. "Malaria symptoms are

Lack of Testing Behind High Minority HIV Infection Rate

BY JOEL B. FINKELSTEIN

Contributing Writer

WASHINGTON — Widespread testing would likely blunt the high HIV infection rate among African Americans and Latinos, but little money and effort have been put into prevention, experts said at the National Minority Quality Forum's 2008 Leadership Summit.

"African Americans and Latinos suffer disproportionately from the HIV/AIDS epidemic in this country," said Dr. Madeline Sutton, who helps lead the Heightened National Response to the HIV/AIDS Crisis Among African Americans, a program of the Centers for Disease Control and Prevention.

Dr. Sutton is the latest director of the \$45 million effort to expand the use of HIV testing; that effort has suffered from revolving leadership, however, and has so far not had overwhelming impact, according to the AIDS community.

"Test everyone and treat everyone. Those are probably the two things we can do right now," said Dr. John Bartlett, chief

of the division of infectious diseases at Johns Hopkins University, Baltimore.

An HIV test costs approximately \$15, which is relatively inexpensive, Dr. Bartlett said, pointing out that it is highly accurate and detects a disease that is lethal if not treated and manageable when it is.

It's a "dream test," yet it's not being used, he said at a meeting sponsored by the Alliance of Minority Medical Associations, the National Association for Equal Opportunity in Higher Education, and the Department of Health and Human Services.

That the test is underused translates to more transmission. The rate of infection is four- to fivefold higher among individuals who don't know they have the disease. Currently, 40% of the people who test positive for HIV have had the infection for 8-10 years, he noted.

Minorities face obstacles that researchers are still struggling to identify. For African Americans, it's not clearly genetics or behavior that is leading to the explosion in the infection rate, Dr. Sutton said.

In part, the CDC's effort is based on forming a better understanding of what the barriers are to testing, so that they can be addressed. "A lot of issues have to do with stigma and how we get people to the next level," she said.

Latino patients face the same barriers and more, given the inherent stigma created by the immigration debate, said Britt Rios-Ellis, Ph.D., director of the Center for Latino Community Health, Evaluation, and Leadership Training, a partnership between the National Council of La Raza and California State University, Long Beach.

"Latinos are the only minority group to see a doubling of HIV infection due to heterosexual contact, from 5% to 12% for males and from 23% to 67% for females between 2001 and 2006. And research in rural Mexico is indicating that most of the women who have AIDS there are married. We're seeing the same pattern here," she said.

For both Latinos and African Americans, the message is the same: By getting tested and treated, they can do something not

only for their families and their communities, but for themselves as well.

"We see that 86% of our [federal] dollars have been spent on biomedical solutions, and those people who are receiving testing and care are doing very, very well. If we could get everyone into testing and care, we know that we would make a difference," Dr. Rios-Ellis said. ■

Coding Guide for HIV Testing

The American Academy of HIV Medicine has released a new CPT coding guide in partnership with the American Medical Association.

The guide is intended to help health care providers and their billing staffs become familiar with the proper coding for claims forms related to HIV testing as a routine part of medical care. The guide is available at www.aahivm.org/images/stories/pdfs/brochure_cpt_guide_routinehivtest.pdf. ■