As I did in my last editorial, I will begin with the subject of Ebola. The outbreak in West Africa is still not under control. A case has been reported in a sixth country, Mali, in a girl who had travelled there from Guinea, though at the time of writing Mali was preparing to release from quarantine 108 potential contacts prior to declaring that it had contained the outbreak there. Healthcare workers returning home from West Africa have in some instances been treated as heroes, but others have been surrounded by controversy. A prime example was the case of Kaci Hickox, the American nurse who defied attempts by the state of Maine to close quarantine her during the 21 day observation period following her return to the USA, and her boyfriend who felt obliged to withdraw from his college course because of the fears of his fellow-students. Education about Ebola and its transmission is needed not only in West Africa but around the whole world, including those countries that supply volunteers to the infected countries. To avoid unnecessary panic, populations need to be made aware that although Ebola has a 21 day incubation period during which monitoring for the development of symptoms is needed, there is no risk of transmission unless symptoms such as fever are present, and there is no risk of airborne infection.

I also referred in my previous editorial to the coming of NECTM6, the 6th Northern European Conference on Travel Medicine, to London in 2016. The dates and venue have now been arranged, 1-4 June 2016 at the Queen Elizabeth Conference Centre, Westminster. We will keep members informed as further details become available.

During this year we have run a series of successful regional educational meetings in Lancaster, Gateshead, Cambridge, Stirling and Winchester sponsored by Norgine and a one-off meeting in Sheffield sponsored by Clasado. We were intending to continue the Norgine sponsored meetings and had several other venues in mind, but because of internal re-structuring in Norgine their funding for these meetings has been withdrawn. This has been a big disappointment to us, but we are actively looking into other potential educational activities such as online learning programmes and webinars. These are very exciting projects which could enable us to reach a far larger audience than we could with face to face meetings, and should we be able to develop them further we will keep members informed as to their progress.

In addition to our own conferences and educational activities we are increasingly raising our profile at events put on by other organisations. Next year we will be present at the Health and Wellbeing at Work conference in March and the Primary Care and Public Health conference in May, both at the NEC Birmingham. At these conferences we will not only have a stand in the exhibition area but we have had large input into organising the global and travel health content of these meetings and will be providing several of the speakers. We will be publicising both these conferences nearer to the time, so please look out for further announcements, as I am sure that there will be something of interest to our members at both of them.

It is my great pleasure to publish in this edition an article from one of our Patrons, Baroness Cox. I am sure you will all enjoy reading it, and there may be more to follow in a future edition. Finally, some news about another of our Patrons, Sir Chris Bonington, who recently celebrated his 80th birthday by revisiting the famous climb of the Old Man of Hoy, which many much younger people would find a considerable challenge.

Mike Townend
It has been my privilege to visit some of the most beautiful places in the world: the dramatic mountains and deep rivers of the lands of the peoples of the Hill Tribes in North-East India and Northern Burma; the starkly beautiful, bleak mountains of the historic lands of Armenia, with some of the most ancient churches in the world nestling in wooded valleys or standing proudly on hilltops; and, in the vast continent of Africa, the wide-open spaces of desert in Sudan with the ever-changing colour of sunshine dancing on shifting sand, and the vast expanse of green, fertile bush-lands in Nigeria, interrupted by rugged mountains erupting from the plains.

However, on my travels, the exhilaration of beauty is inextricably linked with sadness as we know we are about to enter a heart of darkness. My journey’s destinations are lands of people suffering from oppression, persecution, war or the aftermath of war. I travel with the small NGO HART (Humanitarian Aid Relief Trust) which I founded to help victims of cruel regimes inflicting systematic suffering on their own people. In some of these situations, the ruling regime does not allow humanitarian aid organisations to visit its victims, so they are left unreached, unhelped and unheard. HART was established to reach such people, with aid and advocacy. We work with local partners who are committed to helping their own people. They always humble and inspire us with their dedication, integrity, resourcefulness and resilience.

Therefore, we are doubly privileged: our travels in beautiful lands enable us to be alongside amazing people, helping them to make a transformational difference for their communities in very challenging parts of the world.

Please ‘come, and travel with me’ to visit one of our partners in the historic land of Nagorno Karabakh. If you have never heard of it - join the club! Neither had I, until my first visit in 1991, as parts of the Soviet Union were erupting into turmoil and war. Azerbaijan took this opportunity to attempt ethnic cleansing of the Armenians from this little land with systematic and brutal deportation of towns and villages, escalating into full-scale war. By 1992, the Armenians were forced to try to defend their families and their land, armed only with hunting rifles against tanks. I used to count 400 Grad missiles raining down on the little capital city, Stepanakert. This was one of the most high-intensity conflicts of the early 1990’s. A ceasefire was signed in 1994, which has largely been maintained until now, although sniper incidents do still sadly disrupt the peace along the 160km front line.

I always say about the Armenian people that they do not just survive (genocide, earthquake and war against seemingly impossible odds); they create beauty from the ashes of destruction. Nowhere is this truer than in this little land of Karabak. Towns and villages still bear the scars of war; but are being rebuilt with inspirationally aesthetic style. Priorities include rebuilding of churches (destroyed by the Soviets and by war); art galleries and museums. Now there are delightful, clean and comfortable hotels with all ‘Mod. Cons’ and tree-lined boulevards with stylish cafés and restaurants where the visitor can enjoy delicious local and international menus, all set in a land of stunning beauty.

It is the privilege of my small NGO, HART, to support a Rehabilitation Centre in Stepanakert. Our visionary Director Vardan Tadevosyan has transformed a bomb-damaged old school building into an internationally recognised state-of-the-art facility, bringing innovative therapeutic repertoires to people with disabilities in Karabakh and across the South Caucasus.

During the war, there was a high risk of infectious diseases spreading like wildfire as women and children were forced to live for months in overcrowded basements and cellars with no electricity or running water. Diphtheria was beginning to re-emerge in neighbouring Azerbaijan and Karabakh was inevitably very vulnerable to the spread of this and other diseases. I was delighted when MERLIN (Medical Emergency Relief International) accompanied me on a visit to assess the situation and agreed to establish an Immunization Programme for the whole of Karabakh. Their brave team stayed throughout the war years and the Immunization Programme has been maintained until today.

The health care system now functions well and there is a brand-new hospital in the centre of the capital city, Stepanakert. Provincial hospitals and clinics are gradually being restored from grimy, war-torn, Soviet style buildings to modern, bright and well-equipped facilities.
It is not surprising that visitors from around the world now travel to this little land, via the historically fascinating land of Armenia. Eight of my ten grandchildren have accompanied me for transformational experiences. They have witnessed for themselves how people can survive horrendous suffering with dignity, and rebuild their land with indomitable courage combined with aesthetic inspiration.

It has been my privilege to travel 82 times to Armenia and Karabakh. Many of these visits were during the horrors of the war; many during the subsequent years of cease-fire. It has been humbling and inspiring to witness the ‘Spirit of Armenia’ rising like a Phoenix from the ashes of death and destruction, enabling the people to share with visitors their love of their land, their history and their rich culture of music, dance, art - all in the context of the breath-taking beauty of their land’s rugged mountains, thick forests, fertile valleys and crystal rivers.

Truly, one of the most fascinating places and some of the most inspirational people it has been my privilege to visit.

Caroline (Baroness) Cox
House of Lords and CEO of HART
Courses and Conferences

The 16th Annual Conference, British Global and Travel Health Association in association with the Royal College of Physicians and Surgeons of Glasgow.

28 March 2015, De Montfort University, Gateway, Leicester

Website: http://www.bgtha.org

Health and Wellbeing at Work Conference (includes a session on travel health)

3-4 March 2015, National Exhibition Centre, Birmingham

Website: http://sterlingevents.co.uk/about-hw.html

Primary Care and Public Health Conference (includes a session on travel health)

20-21 May 2015, National Exhibition Centre, Birmingham

Website: http://sterlingevents.co.uk/about-pc.html

The 14th Conference of the International Society of Travel Medicine

24-28 May 2016, Québec City, Canada

Website: http://www.istm.org/cistm14

Advance notice

6th Northern European Conference on Travel Medicine

1-4 June 2016, Queen Elizabeth II Conference Centre, London

Further details to follow when available

Advance notice

11th Asia Pacific Travel Health Conference

2016, Kathmandu, Nepal

Dates and venue to be announced

This is an example of a classic medical textbook and is still of huge value for those planning or intending to work in poorer countries. Sadly it is now no longer in print and is likely to be available only in medical libraries. It is an extremely readable book that can be dipped into or read as whole.

I would highly recommend trying to get hold of a copy for anyone planning to work in countries where laboratory tests, x-rays, endoscopic and other investigations are unavailable or only available for the few that can afford them.

The book starts off by looking at medical practice from an ethical perspective and how best to study and learn the basic principles of clinical diagnosis when a detailed history and examination are the cornerstones of making an accurate diagnosis. I hope readers of this review will understand how vital this is in countries with limited laboratory facilities. The approach taken is to recognise that both science and art are involved in medical practice which focuses on compassionate and effective care which sadly can easily be overlooked when investigations are seen as the first priority. How often do we routinely send off a wide range of ‘screening’ tests without knowing why we are requesting them or go straight for a chest x-ray before thoroughly examining the chest?

In the introductory chapters, a detailed description of history taking, general observations and the importance of recognising different types of fever are discussed. Then the author goes into detail, using the above principles, into the symptoms and signs of disease and how to elicit them in each bodily system.

Some of the explanations and differential diagnoses given will seem out of context in countries such as the UK with highly developed health (some would say ‘disease’) services - for example, when discussing aortic regurgitation, rheumatic fever and syphilis are mentioned first, before arteriosclerosis, congenital causes and endocarditis. However this shift of emphasis is vital for those intending to practise in countries where poor nutrition, hygiene and exposure to infections and environmental toxins remain as was the case in the UK until as late at the mid-twentieth century. When I worked in rural India in the 1970s, our head of department compared the disease spectrum we were seeing with the UK in the mid-nineteenth century and in many areas of India and Africa conditions remain the similar. For example, there was little or no understanding of infection in terms of being due to microorganisms passed on through food, water and respiratory droplets and hence potentially preventable.

Maybe copyright rules would make it difficult but if a 4th edition of this book could be written now, retaining the basic premise that history and examination are still cornerstones of diagnosis, I think it could be still be a best seller!

Eric Walker
The General Medical Council has issued advice for doctors in the UK who may be asked to treat a patient who has, or who may have, Ebola. They have taken as their starting point Paragraph 58 of their document Good Medical Practice, which states that “You must not deny treatment to patients because their medical condition may put you at risk. If a patient poses a risk to your health or safety, you should take all available steps to minimise the risk before providing treatment or making other suitable alternative arrangements for providing treatment”.

They point out that in the case of infectious disease, doctors should take all available steps to ensure that they are suitably equipped, for example, with protective clothing, to minimise the risk of transmission before providing treatment. They must also ensure that their clinical judgement and assessment of risk, both to themselves and to others, are informed by up to date information from authoritative sources such as Public Health England, Public Health Scotland, Public Health Wales and Public Health Agency Northern Ireland.

Do doctors have to treat people with Ebola? The implication of Paragraph 58 of Good Medical Practice cited above is that doctors have a duty to ensure that patients have access to appropriate care, but not necessarily to provide care personally. There may be reasonable and defensible reasons, such as the doctor’s own health placing them at increased risk of infection, for asking another suitably qualified clinician to take over the care of the patient.

Doctors who are in management roles should ensure that staff have the necessary equipment and the right information to treat patients while minimising the risk to themselves.

What if doctors are concerned about the equipment and information available?

If doctors are concerned about the risk to themselves, for example because of lack of information or equipment available, the GMC advise that they discuss these issues at local level, with their employer or contracting body, in line with GMC guidance in their publication Raising and Acting on Concerns about Patient Safety.

Will the GMC take action if a doctor refuses to treat a patient who has, or may have, Ebola?

Failure to follow the GMC’s guidance does not automatically mean that they will take action. This is because the guidance sets out the principles of good practice, not thresholds at which the GMC think a doctor is safe to work. The primary requirement for all doctors is to respond responsibly and reasonably to the circumstances they face. If they receive a complaint, they will consider it on its merits, taking account of all the circumstances of the case.

Further information may be obtained from the GMC website, http://www.gmc-uk.org/
The Royal College of Nursing has stated that it will not be publishing independent guidance on Ebola and other viral haemorrhagic fevers but will continue to:

- work with agencies including Public Health England to ensure that systems and processes are in place to support and protect RCN members and other health care workers
- support agencies including Public Health England in preparation for any cases of Ebola entering the UK
- provide RCN members with access to the latest information
- support colleagues and agencies at the European and international level to learn and share information about the experience and contribution of nursing people with or suspected to have Ebola.

They state that as patients with suspected VHF may present outside of hospital or NHS settings, they are advising the following groups to keep up to date with developments and seek advice if required:

- in-flight/repatriation nurses
- practice nurses
- nurses working in assessment or A&E units, including walk-in centres
- nurses in voluntary roles working overseas eg roles associated with non-governmental organisations
- nurses supporting or working with immigration centres
- infection prevention and control nurses / health protection nurses.

They also state that being prepared for suspected cases of VHF is not new and NHS organisations have a responsibility to have policies and procedures in place. The RCN is encouraging all health care organisations to take this opportunity review their preparedness arrangements. This includes ambulance trusts and other organisations that may be contact points for patients outside of hospitals.

The RCN advises that organisations may wish to consider:

- staff knowledge and awareness of existing local infection prevention and control policies for the management of VHF and key contact points within and out of hours
- availability of protective clothing to manage patients presenting efficiently and effectively — consider the use of a ‘high risk infection grab bag’ in a dedicated place containing all necessary equipment and available 24 hours a day (Note: such a resource supports the management of a number of high risk infections, not just VHF)
- ensure staff that to be involved in the care of any patient presenting with Ebola-like symptoms have been trained on how to put on and take off relevant PPE (this is for local determination)
- FIT testing of respiratory protection — consider whether refresher training is required for some staff groups
- awareness of staff on how to apply and remove personal protective equipment in the correct order and procedures to follow following removal
- availability of suitable isolation facilities should they be required in line with Department of Health and HSE guidance (see link to Advisory Committee on Dangerous Pathogens guidance below)
- requirements and risk control measures identified by the Health and Safety (Sharp Instruments in Healthcare) regulations.
Leech bites and the importance of protection

What are leeches?

Leeches are segmented worms. They commonly live in rainforest and jungle environments around the world, particularly South East Asia. Travellers with an itinerary that takes them trekking through rainforest and jungle environments can be at significant risk of coming into contact with leeches as they walk through damp humid areas and wade through freshwater and rivers.

Leeches wait on jungle vegetation such as leaves, twigs and low-lying shrubs. They easily attach themselves to clothes and make their way to the lower legs where they can weave their way through socks and into trekking boots, often biting around the feet. Some leeches can make their way to other areas such as the mouth, nostrils and genital areas and are a particular risk to those who bathe in fresh water.

Leech bites are often painless so are not always obvious, however bloodstained socks and clothing are a clue to their presence. When leeches bite, their teeth clamp on to the skin and with a suction-like action start to feed on the host’s blood. Leeches feed for around 30 minutes but are known to feed for longer. Once they have finished feeding they will naturally detach themselves from the skin to digest. Leeches are not known to spread disease however careful removal of leeches is important to avoid subsequent infection in the wound.

Removing leeches

It is extremely difficult to detach a leech from the skin whilst it is feeding and if it is pulled off the skin, the wound is likely to bleed due to the anticoagulant they release to feed. There is also a risk that the wound will become infected and ulcerated which may cause scarring. The best thing to do is to wait until the leech has finished feeding and detaches itself.

In an emergency, salt, a lighter flame or cigarette are some methods that can be used to irritate the leech enough that it will release itself from the skin. There is a risk however that these methods of removal can cause the leech to vomit its stomach contents into the wound and cause infection. Leech bite wounds can bleed for some time. Bleeding can be reduced by applying pressure to the wound. An antiseptic should then be applied to clean the area which must be kept clean and dry to prevent any infection. The wound may itch as it begins to heal but it is important to avoid scratching as this can delay the healing process and introduce infection. Taking a topical or oral antihistamine can help reduce any itching.

Leech bite wounds can bleed for some time. Bleeding can be reduced by applying pressure to the wound. An antiseptic should then be applied to clean the area which must be kept clean and dry to prevent any infection. The wound may itch as it begins to heal but it is important to avoid scratching as this can delay the healing process and introduce infection. Taking a topical or oral antihistamine can help reduce any itching.

Personal protection

Personal protection is extremely important. Any traveller trekking in hot humid conditions where leeches are known to be a problem should wear leech socks to protect themselves. Leech socks come up over the knee and are made of tightly woven fabric that prevents leeches finding their way to skin. Leech socks should be worn over socks but under trekking boots. Treating leech socks with 100% DEET will offer greater protection.

If necessary, it is possible to make your own leech socks. This can be done by treating ordinary hiking socks with 100% DEET. These should then be worn pulled up towards the calf to cover the leg as much as possible.

Travelproof leech socks are available from nomad stores and online at www.nomadtravel.co.uk. They are made from a tough, soft, ultra-quick drying material and are based on the actual design worn by the Park Rangers in Thailand, simply wear them over your socks but under your trekking boots. One Size Fits All.

Beverley Tompkins RN AFTM RCPS (Glasg)
Specialist Travel Health Nurse
My career has moved between appointments as Consultant in Infectious Diseases (with a special interest in Tropical Diseases and Travel Medicine), General Practice, overseas appointments and in Health Protection Scotland. This led to the developments of the TRAVAX and Fit for Travel websites, the Glasgow Travel Medicine Courses and the establishment of a Faculty of Travel Medicine in the Royal College of Physicians and Surgeons, Glasgow. I was a founder member of the British Travel Health Association and have supported its move to become the more inclusive and accurately descriptive British Global and Travel Health Association.

I have spent time in Africa but particularly in India with Madras University and Vellore Christian Medical College and which I regularly revisit. For 10 years, I was principal UK coordinator of British Council sponsored research and educational projects in India on Hepatitis and HIV/AIDS until 2007. Having retired from clinical practice I continue teaching as an Honorary Associate Professor in the Department of General Practice and Primary Care at Glasgow University where I help with courses on Global and Travel Health. I represent the BGTHA on the organising committee for the popular biennial Northern European Conferences in Travel Medicine.

Having grown up on a “traditional farm” and have a long-standing interest and serious concerns for how we so often seem to neglect the environment on which our health depends and how this is influenced by modern day lifestyles and the exponential increase in long-distance travel and trade. I lecture on this topic, keep bees, maintain a “sustainable garden” including a naturally productive “forest area” and am co-director of Good Green Fun which is a charity that collects donations and recycles children’s items such as baby equipment, prams, clothes, toys etc., selling them on at low prices - we recently won a Stirling provost’s award for service to the community. I play the viola with the Stirling Orchestra.

Katy Peters is the director and co-founder of 360 Health Limited, through which she runs private travel clinics in the capital, London. She is a nurse prescriber and travel health specialist with over 8 years’ experience in tropical and travel medicine.

Katy has extensive clinical experience throughout the world including with Médecins Sans Frontières in the Democratic Republic of Congo as an outreach nurse, in Sikkim North East India working as a School nurse and The Bahamas in neonatal intensive care. Katy’s UK experience includes working in the Welsh Regional burns unit, general and neurological intensive care and practice nursing. Katy is involved in the education and training of travel health nurses and as a speaker for vaccine suppliers.

Katy holds a Bachelor of Nursing from University of Wales and a Diploma in Tropical Nursing from London School of Hygiene and Tropical Medicine. She holds a Post Graduate Certificate in Non-Medical Prescribing from London South Bank University. She is currently undertaking the diploma in Travel Medicine at the Royal College of Physicians and Surgeons in Glasgow.

She continues to travel where possible with her 4 year old son Bear; recently returning from a month's backpacking in S.E Asia.
NECTM6 comes to London

Advance notice

As we announced in the previous edition of Travelwise, the Northern European Conference on Travel Medicine will take place in London in 2016 with BGTHA as the lead organisation in hosting it. The Local Organising Committee consists of Tania John, Eric Walker and Mike Townend representing BGTHA, Dipti Patel representing NaTHNaC and Sandra Grieve representing the RCN, with Fiona Genasi as an additional adviser.

We can now announce that the conference will be held in from 1 to 4 June 2016 at the Queen Elizabeth II Conference Centre, Westminster. We will keep members fully informed about the programme and registration details when they become available, but for now please put these dates in your diary. As there will be no BGTHA Annual Scientific Meeting in 2016, we hope that as many BGTHA members as possible will avail themselves of this opportunity to attend a major travel medicine conference in their own country.
Q:

Please explain the new rules on the administration of more than one live vaccine.

A:

For many years, it has been recommended that when two live vaccines are needed by the same individual, they should either be given simultaneously (defined as on the same day) or at least four weeks apart.

Public Health England, through its circular 1 in September 2014, has changed this rule to the following:

- MMR and Yellow Fever vaccines: do not administer these two vaccines on the same day. They must be separated by at least 4 weeks. This is because giving them simultaneously can lead to suboptimal antibody response to mumps, rubella, and yellow fever. The exception is when these need to be administered as soon as possible and as a matter of urgency. In this case they can be given at any interval shorter than 4 weeks but an additional dose of MMR may be considered.

- MMR and Varicella (chickenpox): either administer on the same day or separate by at least 4 weeks

- Varicella Zoster (shingles vaccines) and MMR or Yellow Fever: separate by at least 4 weeks (The Green Book 2)

- All currently available live vaccines in the UK (BCG, Rotavirus, Live attenuated influenza vaccine intranasal, Oral Typhoid, Yellow Fever, Varicella, Varicella Zoster, and MMR): Apart from those mentioned above, these live vaccines can be administered at any time before or after each other.

George Kassianos
Conferences can be an opportunity to separate us from our daily work and give time for reflection, learning from others, share ideas, get new ideas about our career path, meet colleagues and make new friends. They can be on way of building up our Continuing Professional Development (CPD) that may useful it comes to appraisal and revalidation. Nurses soon join doctors in having to participate in these schemes. Some like to call them scientific conferences although if this is taken to mean solely the presentation of scientific research papers then the expression is inappropriate for travel medicine conferences when a large proportion of the presentations are educational. This does not however mean that the presentations fail to be ‘evidence based’ so long as the speakers are chosen carefully!

Travel Medicine is well endowed with conferences, symposia and study days - some say there are too many but in my experience they are usually well attended. However, who actually goes to them? They can be expensive when you add up the conference registration fee, travel costs and accommodation. This can be a problem if your place of work is not sympathetic to this form of further education and will not agree to contribute to the costs or arrange cover for you to have time off.

If you are one of the lucky ones and are able to participate, it is a good idea to select carefully which conferences or other forms of continuing education might give you you the greatest benefit considering also the needs of your practice. They are usually multi-disciplinary and there is choice between local, and national meetings (mostly lasting up to one day). Then there are international ‘regional’ or ‘global’ meetings that can be 2-3 days or more. For larger conferences planning can take at up to 2 years and a professional conference organiser company is usually involved. Cost depends upon predicting the likely numbers of registrations, which is difficult and can be a ‘headache’ for organisers when participants register late. This is one reason why deposits or sponsorship from companies may be sought to get some reassurance that a conference is likely to be financially viable at an earlier planning stage. Sometimes if organisation runs a regular event it likes to build up a reserve fund to carry over from one conference to the next.

The formal side
- Plenaries, Symposia and Workshops: Travel Medicine Conferences usually involve a substantial number of educational sessions including plenaries (for everybody), symposia (several run in parallel). ‘Workshops’ may be included when audience participation is encouraged - the extent of participation depends upon the numbers involved and is greater if small group sessions are included. Topics are chosen by the conference’s organising committee and ideally should reflect the anticipated needs and interests of likely participants. Symposia and workshops, in particular, can offer a broad choice of subjects and include last minute open sessions to look at topical issues.

Eric Walker

Why do we attend Conferences?
Introducing Yellow Fever Vaccination:

Currently, the International Health Regulations stipulate that vaccination with an approved yellow fever vaccine provides protection against infection for 10 years, and that the certificate of vaccination or re-vaccination is accordingly valid for 10 years. Requiring the certificate from travellers is at the discretion of each State Party, and it is not currently required by all countries.

The WHO World Health Assembly in May 2014 adopted an amendment to Annex 7 of the International Health Regulations (2005), which stipulates that the period of protection afforded by yellow fever vaccination, and the term of validity of the certificate will change from 10 years to the duration of the life of the person vaccinated.

This change will enter into force legally in June 2016. Until then the current IHR text on yellow fever vaccination and certificates continues to apply, and some countries may continue to request proof of vaccination or a booster within the last 10 years from travellers.

Starting with the online 2015 International Travel and Health edition, WHO will report on the status of yellow fever vaccination requirements for countries.

Reference

Congratulations

We would like to congratulate our Hon Secretary James Moore on being elected a Fellow of the Faculty of Travel Medicine of the Royal College of Physicians and Surgeons, Glasgow. Along with our President, Dr George Kassianos, our Immediate Past President Dr Iain McIntosh, our Chairman Dr Mike Townend and committee member and former office-holder Dr Eric Walker, James will become the fifth member of your committee to receive this honour out of a current total of only 101 Fellows.