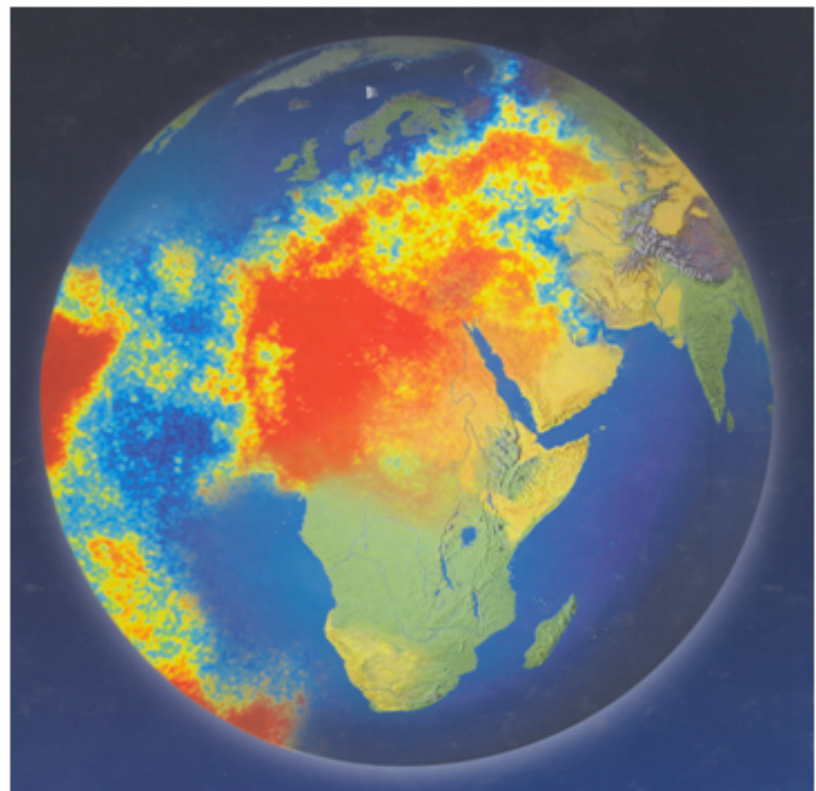


# TropNetEurop

11<sup>th</sup> Workshop on

Imported Infectious Diseases

2010



August, 28<sup>th</sup> - 29<sup>th</sup>

Leiden



European Network on Imported Infectious Disease Surveillance

[www.tropnet.eu](http://www.tropnet.eu)

## PROGRAMME

### 11<sup>th</sup> TropNetEurop Workshop 28-29/08/2010

Date & Time		Speakers
<b>Saturday, 28/08/2010</b>		
09 <sup>00</sup> -09 <sup>15</sup> 09 <sup>15</sup> -09 <sup>30</sup>	Introduction Tropical Medicine & Infectious Diseases in Leiden	Leo Visser, Leiden
09 <sup>30</sup> -10 <sup>15</sup>	Report of steering committee and co-ordinator <ul style="list-style-type: none"> <li>• Membership issues</li> <li>• Reporting</li> <li>• Data management</li> <li>• Events of the last year</li> </ul>	Ron Behrens, London Zeno Bisoffi, Verona Joaquim Gascon, Barcelona Tomas Jelinek, Berlin Nick Mühlberger, Hall Leo Visser, Leiden
10 <sup>15</sup> -10 <sup>45</sup>	<b>Break</b>	
10 <sup>45</sup> -12 <sup>15</sup>	Report of steering committee and co-ordinator (continued) Election of Steering Committee and Network Coordinator	
12 <sup>15</sup> -13 <sup>15</sup>	<b>Lunch</b>	
13 <sup>15</sup> -13 <sup>45</sup>	Newer diagnostic approaches to intestinal and helminthic parasites	Lisette van Lieshout, Leiden
13 <sup>45</sup> -14 <sup>15</sup>	S-E Asia study	Ron Behrens, London
14 <sup>15</sup> -14 <sup>45</sup>	Malaria Diagnostics, the next generation	Peter Chiodini, London
14 <sup>45</sup> -15 <sup>15</sup>	Artesunate and haemolysis	Thomas Zoller, Berlin
15 <sup>15</sup> -15 <sup>45</sup>	MALTHER Study	Martin Grobusch, Amsterdam
15 <sup>45</sup> -16 <sup>15</sup>	<b>Break</b>	
16 <sup>15</sup> -16 <sup>45</sup>	Presentation of the new Dengue research protocol	Leticia Franco, Madrid
16 <sup>45</sup> -17 <sup>15</sup>	DENCO study: a suggested revised case classification for Dengue fever	Thomas Jänisch, Heidelberg
17 <sup>15</sup> -17 <sup>45</sup>	Imported mycoses: neglected and unrecognized: French data	Michel Develoux, Paris
17 <sup>45</sup> -18 <sup>00</sup>	Tropical Medicine in Amsterdam	Martin Grobusch, Amsterdam
18 <sup>00</sup> -18 <sup>15</sup>	The Faculty of Travel Medicine	Peter Chiodini, London
20 <sup>30</sup>	<b>Dinner</b>	
<b>Sunday, 29/08/2010</b>		
9 <sup>00</sup> -9 <sup>15</sup>	Introduction	Tomas Jelinek, Berlin
9 <sup>15</sup> -9 <sup>45</sup>	Melioidosis imported from West Africa to Spain	Juan Cuadros Gonzales, Alcala - Madrid
9 <sup>45</sup> -10 <sup>15</sup>	Imported Loiasis	Spinello Antinori, Milan
10 <sup>15</sup> -10 <sup>45</sup>	Cystic echinococcosis, an orphan disease in Europe	Peter Chiodini, London
10 <sup>45</sup> -11 <sup>15</sup>	<b>Break</b>	
11 <sup>15</sup> -12 <sup>00</sup>	Schistosoma PCR-test in the diagnosis of acute schistosomiasis	Jan Clerinx, Antwerp
12 <sup>00</sup> -12 <sup>30</sup>	Katayama fever: presentation of two cases with lung involvement and discussion of treatment	Jose Muñoz, Madrid
12 <sup>30</sup> -13 <sup>00</sup>	Rabies vaccine study	Ron Behrens, London
13 <sup>00</sup> -13 <sup>30</sup>	Hepatitis B & Schistosomiasis co-infection	Matthias Schmid, Newcastle-upon-Tyne
13 <sup>30</sup> -14 <sup>30</sup>	<b>Lunch &amp; Farewell</b>	

## WORKSHOP ORGANIZER AND LOCAL CONTACT ADDRESS

Dr. Leo Visser

Leiden University Medical Centre

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Mobile: +31 6 21936886

E-mail: l.g.visser@lumc.nl

## MEETING VENUE

The meeting will take place at the Leiden University Medical Centre

**WELCOME**

Dear colleagues,

Leo Visser

---

Dear colleagues!

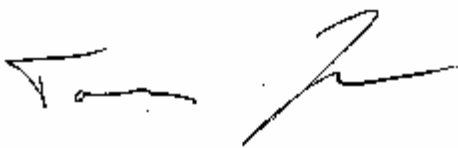
TropNetEurop has now finished its 11<sup>th</sup> successful year. The network has become an widely accepted provider of reliable surveillance information on European and international level. It has also grown substantially over the last two years. TropNetEurop unites 57 specialized centres all over Europe. Within the network, we see an average of 48.000 patients post travel per year. TropNetEurop remains by far the largest network on imported infectious disease surveillance globally. We have managed to develop TropNetEurop into a renown reference in the field of imported infectious diseases. The large output of widely distributed material shows the value of our work.

This continuous success is achieved through considerable effort from all members who put in extra time and work to make the network possible. It is also made possible by dedicated individuals who deal with the reports and the data management. In particular, I wish to express my thanks to Jutta Kerling and Dr. Nikolai Mühlberger who have provided invaluable input to the network over the last years.

This meeting will see a change of coordinator, as I will not stand for re-election. The steering committee has given this issue quite a bit of thought and will present its proposal. So, I am looking forward to an exciting meeting in Leiden!

On behalf of all members of the network, I wish to express our special thanks to the local organising team of this workshop, especially to Leo Visser, who made the meeting possible.

Berlin, August 23<sup>rd</sup>, 2010



Tomas Jelinek

## ACKNOWLEDGEMENTS

Financial support for the workshop from following sources is gratefully acknowledged:

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## MISSION AND GOALS OF TROPNETEUROP

- ❖ to maintain a collaborative network of European professionals dealing with imported infectious diseases;
- ❖ to create European consensus for clinical guidelines for diagnostic and therapeutic procedures in imported infectious diseases;
- ❖ to identify emerging pathogens by sampling returning international travellers, immigrants, and foreign visitors;
- ❖ to add information and accuracy to the current, divergent European systems of disease notification;
- ❖ to provide grounds for cluster investigation and intervention strategies by Public Health authorities;
- ❖ to provide the basis for permanent research collaboration of infectious disease centres in Europe

## TROPNETEUROP: RULES & REGULATIONS

1. Membership only by clinical sites, no minimal number of patients
2. Exclusion criteria for members need to be defined, steering committee also decides on inclusion
3. Management structure: every site has one site manager and one vote ( only when submitting data!)
4. Steering committee: five members including one network coordinator( elected for two years)
5. Regular meeting of membership every year necessary
6. All members decide on fundamental issues regarding the network
7. Members should decide on steering committee work at annual meetings:  
steering committee submits questions, proposals to all members, reviews research proposals
8. Network coordinator manages day-to-day work
9. Data are owned by all reporting members
10. Publication of results: all site managers of reporting sites are named as co-authors (in order of number of reported patients). TropNetEurop should always be mentioned. All publications go through review by steering committee.
11. Ownership of funds: though network infrastructure should be financed, funds will be managed by members that applied for them

### TropNetEurop: functions within the network

#### Steering Committee

- ▲ Executes decisions of membership
- ▲ Controls coordinator
- ▲ Foreign policy
- ▲ Structural decisions, e.g.
  - ✗ recruiting of new member sites
  - ✗ changes in questionnaire
  - ✗ uptake of research projects

controls



reports



#### Coordinator

- ▲ Executes decisions of membership and Steering Committee
- ▲ Ensures communication within the network
- ▲ Maintains data base
- ▲ Produces reports
- ▲ Ensures anonymity of data

#### Membership

- ▲ Fundamental decisions, e.g.
  - ✗ reporting of additional diseases
  - ✗ data merger with other networks, etc.
  - ✗ elects steering committee
  - ✗ elects coordinator

elects  
controls

reports

reports

elects  
controls



## CURRENT SITUATION OF TROPNETEUROP



TropNetEurop has started in April, 1999 with few selected members of TropMedEurop, the European Association for Tropical Medicine. From the beginning, support has been surprisingly strong and it has been very easy to recruit new member sites. TropNetEurop covers now 12% of all malaria patients in Europe and probably a similar percentage of patients diagnosed with dengue fever and schistosomiasis. The network has broadened its scope in membership with

including sites who are not active in TropMedEurop and is now uniting many European centers of excellence in imported infectious diseases. After a major consolidation phase during the second half of 2000, when several inactive members opted to join the mailing list “friends & observers” rather than participating in the reporting system, recruitment of new member sites has continued. TropNetEurop wishes to interest all major European “centers of excellence” on Imported Infectious Diseases. Currently, the network has 57 members sites.

	N	%
<b>Member Sites</b>	57	100.0
<b>Sites reporting electronically</b>	34	59.6
<b>Reported Patients</b>	12703	100.0
<b>Patients reported electronically</b>	4499	35.4
<b>Reported Diagnoses</b>	12723	100.0
<b>Malaria</b>	9629	75.7
<b>Schistosomiasis</b>	1461	11.5
<b>Dengue</b>	1429	11.2
<b>Leishmaniosis</b>	204	1.6

## Member sites of TropNetEurop (new members are marked yellow)

No	Institution	Site Director
1.	Department of Infectious Diseases, Aalborg Hospital, Aalborg, Denmark	Dr. H. Nielsen
2.	Department of Infectious Diseases and Tropical Medicine, University Hospital of Aarhus, Skejby Hospital, Aarhus, Denmark	Prof. F.T. Black
3.	Democritus University of Thrace, Alexandroupolis, Greece	Prof. K. Mimidis
4.	Infectious Diseases Unit, Hospital General Universitario de Elche, Alicante, Spain	Dr. José Manuel Ramos
5.	Department of Infectious Diseases, Tropical Medicine and HIV/AIDS at the AMC (Academic Medisch Centrum) of the University of Amsterdam	Prof. Martin Grobusch
6.	Prins Leopold Instituut voor Tropische Geneskunde, Clinical Services, Antwerp, Belgium	Dr. J. Clerinx
7.	Sección de Medicina Tropical, Hospital Clinic, Barcelona, Spain	Dr. J. Gascon
8.	Unitat de Malalties Tropicals, Importades i Vacunacions Internacionals, Institut Català de la Salut, Barcelona, Spain	Dr. J. Gómez i Prat
9.	Swiss Tropical Institute, Basel, Switzerland	Prof. Dr. C. Hatz
10.	Centre for tropical medicine and imported infectious diseases (CTID), Division of infectious diseases, Medical Dept., Haukeland University Hospital, Bergen, Norway	Dr. K. Mørch
11.	Berlin Center for Travel & Tropical Medicine, Berlin, Germany	Dr. T. Jelinek
12.	Medizinische Klinik mit Schwerpunkt Infektiologie, Charite/Campus Virchow-Klinikum, Berlin, Germany	Dr. T. Zoller
13.	Consultation de médecine tropicale, Hôpital Avicenne, Bobigny, France	Dr. O. Bouchaud
14.	Médecine interne et Maladies tropicales, Hôpital St André-CHU, Bordeaux, France	Prof. DJM Malvy
15.	Bradford Royal Infirmary, Infection and Tropical Medicine, Bradford, UK	Dr. P. McWhinney
16.	Clinica di Malattie Infettive e Tropicali, Università di Brescia, Italy	Dr. A. Matteelli
17.	Surgeon General's Department, Army Medical Directorate, FASC Camberley, UK	Dr. A. Green
18.	Consulta de Medicina do Viajante, Departamento de Doenças Infecciosas, Hospital Universitário, Coimbra, Portugal	Prof. S. da Cunha
19.	Department of Infectious Diseases M 5132, University of Copenhagen, Denmark	Dr. I. Gjørup
20.	Tropical Medical Bureau, Dublin	Dr. Graham Fry
21.	SOD Malattie Infettive e Tropicali, Azienda Ospedaliero-Universitaria Careggi, Firenze, Italy.	Dr. A. Bartoloni
22.	J.W. Goethe Universität, Klinik II, Schwerpunkt Infektions- und Tropenerkrankungen, Frankfurt/Main, Germany	Prof. G. Just-Nübling
23.	Division of Infectious Diseases, Department of Medicine, Center for Infectious Diseases and Travel Medicine, University Hospital, Freiburg, Germany	Prof. W. Kern

24.	Institute of Maritime and Tropical Medicine, Gdynia, Poland	Prof. A. Kotlowski
25.	Tropenmedizin, Abteilung Tropenhygiene und Öffentliches Gesundheitswesen, Universitätsklinikum Heidelberg, Germany	Dr. A. Kapaun
26.	Helsinki University Central Hospital, Dpt. of Medicine, Div. of Infectious Diseases, Helsinki, Finland	Dr. H. Siikamaki
27.	Vaccination and Travel Medicine Center, Hradec Kralove, Czech Republic	Prof. J. Beran
28.	Sorlandet Hospital, Kristiansand, Norway	Prof. S.G. Gundersen
29.	Travel Clinic, Policlinique Médicale Universitaire, University of Lausanne, Lausanne, Switzerland	Dr. B. Genton
30.	Dept Infectious Diseases, Section Travel Medicine, Leiden University Medical Centre, Netherlands	Dr. L.G. Visser
31.	Universidade Nova de Lisboa, Instituto de Higiene e Medicina Tropical, Lisbon, Portugal	Dr. J. Atougia
32.	CISCOS, Faculdade de Ciências Médicas, Departamento Universitário de Saúde Pública, Lisbon, Portugal	Dr. N. Gonçalves
33.	Hospital for Tropical Diseases Travel Clinic, London, UK	Dr. R. Behrens
34.	Microbiologia Clínica, Ctra. de Meco, Alcala de Henares, Madrid, Spain	Dr. J. Cuadros
35.	Tropical Medicine & Clinical Parasitology Unit, Infectious Diseases - Microbiology Department, Hospital Ramon y Cajal, Madrid, Spain	Prof. R. Lopez-Velez
36.	Hospital Carlos III, Instituto de Salud Carlos III, Madrid, Spain	Dr. S. Puente
37.	Division of Infectious Disease, Fundación Jiménez Díaz, Madrid, Spain	Dr. M. de Górgolas
38.	Travel Medicine Unit, Hospital General Universitario Gregorio Marañón, Madrid, Spain	Dr. P. Martin-Rabadan
39.	Hospital Sacco for Infectious Diseases, Milan University, Italy	Prof. Spinello Antinori
40.	North Manchester General Hospital, Manchester, UK	Dr Andrew Ustianowski
41.	Department of Infectious Diseases & Tropical Medicine, University of Munich, Germany	Dr. M. Schunk
42.	Centro per le Malattie Tropicali, Ospedale S. Cuore, Negrar (Verona), Italy	Dr. Z. Bisoffi
43.	Department of Infection & Tropical Medicine, Newcastle General Hospital, Newcastle-upon-Tyne, UK	Dr. M.L. Schmid
44.	Department of Infectious Diseases, Ullevaal University Hospital, Oslo, Norway	Prof. B. Myrvang
45.	Service de Parasitologie, Hôpital Tenon, Paris, France	Dr. M. Develoux
46.	Hospital de Joaquim Urbano, rua Camara Pestana, 348, 4369-004 Porto, Portugal	Dr. Helena Coelho
47.	Department and Clinic of Tropical and Parasitic Diseases, Karol Marcinkowski University of Medical Sciences, Poznan, Poland	Dr. M. Paul
48.	3rd Dep. of Infectious and Tropical Diseases, First Faculty of Medicine of Charles University in Prague, Czech Republic	Prof. Pavel Chalupa
49.	INMI L. Spallanzani, Rome, Italy	Dr. P. Ghirga

50.	Central Hospital of Rogaland, Stavanger, Norway	Dr. Åse Berg
51.	Karolinska Hospital, Department of Medicine, Unit of Infectious Diseases, Stockholm, Sweden	Prof. A. Björkman
52.	Karolinska Institute, Division of Infectious Diseases, Huddinge University Hospital, Stockholm, Sweden	Prof. U. Hellgren
53.	Osp. Amedeo di Savoia, Div. "A" Malattie Infettive, Torino, Italy	Dr. Guido Calleri
54.	Clinic of Infectious Diseases, University of Udine, Italy	Dr. A. Beltrame
55.	Sektion Infektionskrankheiten, Universität Ulm, Germany	Prof. P. Kern
56.	Kaiser-Franz-Josef-Spital der Stadt Wien, 4. Medizinische Abteilung mit Infektions- und Tropenmedizin, Vienna, Austria	Dr. H. Laferl
57.	Missionsärztliche Klinik, Würzburg, Germany	Dr. G. Stich

## TropNetEurop: Members and Patient Encounters

Nº	Town	Site Manager	In- and outpatients [per year]	Pre-travel advises [per year]
1.	Aalborg	H. Nielsen	100	200
2.	Aarhus	F. T. Black	350	800
3.	Alexandroupolis	K. Mimidis	500	
4.	Alicante	J.M. Ramos	150	500
5.	Amsterdam	M. Grobusch	1200	13000
6.	Antwerp	J. Clerinx	7700	12000
7.	Barcelona – Hospital Clinic	J. Gascon	1400	6000
8.	Barcelona - Drassanes	J. Gòmez i Prat	6000	12000
9.	Basel	C. Hatz	2500	10000
10.	Bergen	K. Mørch	50	600
11.	Berlin - BCRT	T. Jelinek	2200	15000
12.	Berlin - Charite	T. Zoller	400	0
13.	Bobigny	O. Bouchaud	500	0
14.	Bordeaux	JMD. Malvy	500	12000
15.	Bradford	P. McWhinney	150	0
16.	Brescia	A. Matteelli	400	50
17.	Camberley (UK Armed Forces)	A. Green	0	0
18.	Coimbra	S. da Cunha	50	800
19.	Copenhagen - CMP	I. Gjørup	300	2000
20.	Dublin	G. Fry	1200	12000
21.	Firenze	A. Bartoloni	250	0
22.	Frankfurt	G. Just-Nübling	350	0
23.	Freiburg	W. Kern	250	350
24.	Gdynia	A. Kotlowski	100	200
25.	Heidelberg	A. Kapaun	1400	6000
26.	Helsinki	H. Siikamaki	300	0
27.	Hradec Králové	J. Beran	300	2000
28.	Kristiansand	S. G. Gundersen	50	0
29.	Lausanne	B. Genton	300	12000
30.	Leiden	L.G. Visser	200	2800
31.	Lisbon	J.V. Costa	400	3100
32.	Lisbon	N. Gonçalves	100	3500
33.	London	R. Behrens	5000	8000
34.	Madrid - Principe de Asturias	J. Cuadros	100	100
35.	Madrid - Ramon y Cajal	R. Lopez-Velez	550	0
36.	Madrid - Carlos III	A. Benito	450	0
37.	Madrid - Jiménez Díaz	M. de Górgolas	100	200
38.	Madrid- Gregorio Maranon	P. Martin-Ramadan	600	150
39.	Manchester	A. Ustianowski	150	200
40.	Milan	S. Antinori	200	0

41.	<b>Munich</b>	M. Schunk	1700	13000
42.	<b>Negrar (Verona)</b>	Z. Bisoffi	2000	1500
43.	<b>Newcastle</b>	M. Schmid	1500	300
44.	<b>Oslo</b>	B. Myrvang	1500	5000
45.	<b>Paris</b>	M. Deveroux	1500	6500
46.	<b>Porto</b>	H. Coelho	200	3000
47.	<b>Poznan</b>	M. Paul	100	350
48.	<b>Prague</b>	P. Chalupa	600	500
49.	<b>Rome</b>	P. Ghirga	100	200
50.	<b>Stavanger</b>	A. Berg	100	0
51.	<b>Stockholm - Karolinska</b>	A. Björkman	1500	15000
52.	<b>Stockholm - Huddinge</b>	U. Hellgren	400	15000
53.	<b>Torino</b>	C. Galleri	800	2000
54.	<b>Udine</b>	A. Beltrame	200	0
55.	<b>Ulm</b>	P. Kern	1000	2500
56.	<b>Vienna – KFJS</b>	H. Laferl	450	0
57.	<b>Würzburg</b>	G. Stich	300	450

## COMMUNICATION

### a) The Mailing List ([tropnet@yahoo.com](mailto:tropnet@yahoo.com)) <http://health.groups.yahoo.com/group/tropneteurop/>



The TropNetEurop mailing list is managed by the coordinator. Primarily for reasons of convenience, a group list at Yahoo!.com has been chosen for this purpose. All mailings to TropNetEurop go through this group servers and have been approved by the coordinator. The list server cannot be accessed by

non-members. Only selected messages are forwarded to the outside by the coordinator. The list is one of the most valuable features of TropNetEurop, enabling all members to communicate rapidly in an exclusive setting.

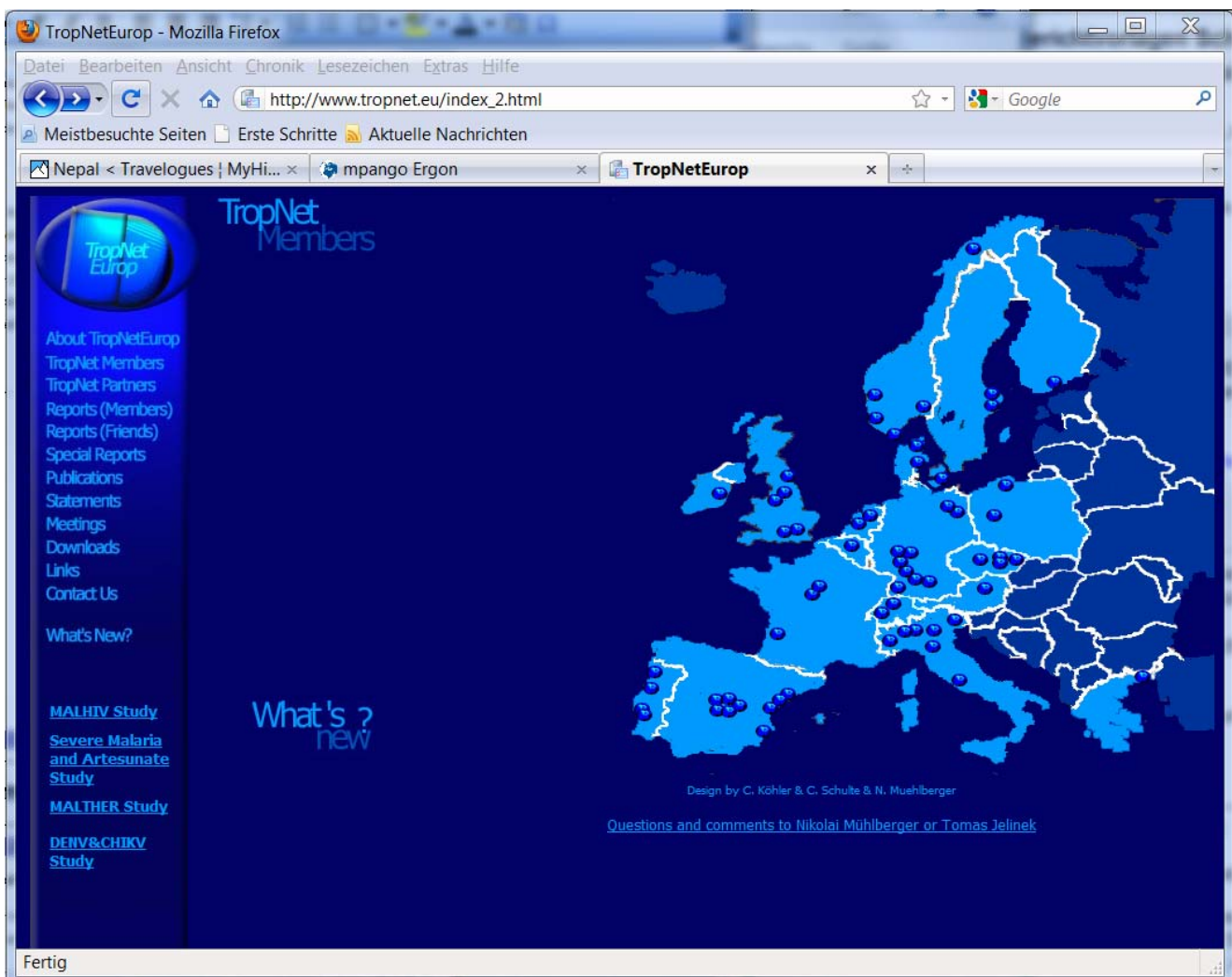
### b) Monthly Reports

Monthly reports on accumulated and analysed data have been mailed on (almost) monthly basis since April, 1999. Outfit and content of the reports have changed, feedback was overwhelmingly positive. TropNetEurop members receive the reports as WinWord-files which is supposed to make use of the graphics in lectures and presentations easy. Every figure can be copied to any presentation programme (such as PowerPoint) and modified for further use. In the same way as data in the data base are owned by all TropNetEurop members, so are reports and their content. Members can use the material without further permission, yet acknowledgement of the network is encouraged.



### c) The Web Site

The TropNetEurop web site can be accessed by everybody at [www.tropnet.eu](http://www.tropnet.eu). The site provides basic information on the network and its members, offers contacts to the coordinator and the members and informs about recent reports and “sentinel events”. A password protected area for members only gives access to all reports of TropNetEurop. We do not monitor access numbers to the web site, but feedback has been predominantly positive. The award-winning site has been created by Clemens Schulte and is now managed by Nikolai Mühlberger.





## f) Special Reports and “Sentinel Events”

The extremely high level of awareness for “sentinel events” of all network members has ensured several impressive successes of TropNetEurop.

tropneteurop: European Network on Imported Infectious Diseases (TropNetEurop) - Mozilla Firefox

http://health.groups.yahoo.com/group/tropneteurop/

Meistbesuchte Seiten | Erste Schritte | Aktuelle Nachrichten

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Activity within 7 days: [New Messages](#) - [New Questions](#)

Description (Edit, Add Photo)

While public health services all over Europe are sorely lacking data on number, nature and impact of infectious diseases that are increasingly imported to the continent, infectious disease clinics dealing with the patients carrying those infections are ideally situated to effectively detect emerging infections of potential global impact at their point of entry into the domestic population.

Thus, the objectives and expected achievements of TropNetEurop are:

1. to maintain a collaborative network of European professionals dealing with imported infectious diseases;
2. to create European consensus for clinical guidelines for diagnostic and therapeutic procedures in imported infectious diseases;
3. to identify emerging pathogens by sampling returning international travellers, immigrants, and foreign visitors;
4. to add information and accuracy to the current, divergent European systems of disease notification;
5. to provide grounds for cluster investigation and intervention strategies by Public Health authorities;
6. to provide the basis for permanent research collaboration of infectious disease centres in Europe.

Partners of the network come from all parts of Europe. Collaborating sites have the opportunity to co-operate within the network at different levels:

- a) all sites receive regular epidemiological information by the co-ordinating site;
- b) reporting sites that collect standardized denominator data on travel-related disease are carefully chosen; and
- c) all sites have the possibility to participate in one or more scientific projects. The projects are designed to monitor emerging infectious diseases of potential public health significance and to provide a baseline of knowledge about the spectrum of infectious diseases that are imported to Europe.

Most Recent Messages (New 4)

Case reports & query from Dublin  
Dear colleagues Below come several case reports from Graham Fry, Dublin. The Mairy Lemon Island is situated in the Nile, by car approx. 2 hours West of  
Posted - Mon Aug 23, 2010 11:13 am

West Nile from Israel  
Dear colleagues Below comes a short case report from Leo Visser, Leiden. Anybody else seen similar patients? Sincerely Tomas ----- Dear  
Posted - Sat Aug 29, 2010 11:37 am

Updated Workshop Programme - pdf file  
Dear colleagues Since some of you have problems with opening the doc-files, I add a pdf here. Sincerely Tomas \_\_\_\_ Von: tropneteurop@yahogroups.com  
Posted - Fri Aug 20, 2010 10:27 pm

Updated Workshop Programme  
Dear colleagues After much shifting and queuing we managed to complete the Leiden workshop programme with all offered presentations included. Please see  
Posted - Fri Aug 20, 2010 10:18 pm

aliskia  
Dear Sir, Could you, please, give me some information on which one is a possible test for the diagnosis of aliskia, for an Italian young man (27 years old)  
Posted - Mon Jul 12, 2010 1:08 pm

Message History

Fertig

e) Friends & Observers (<http://health.groups.yahoo.com/group/tropnetfriends/>)

Following increasing demand, a second TropNetEurop mailing list had to be created. This list is targeting all interested medical staff, that are not able or willing to participate actively at TropNetEurop. It also aims to include public health staff in Europe, at WHO and in countries that are visited by European travellers. This list is managed by the network coordinator and is not open for discussion. Currently it has 69 members. Feedback has been overwhelmingly positive and close contacts to several recipients have developed. This has led repeatedly to the notification of “sentinel events” through members of this mailing list to TropNetEurop.

The screenshot shows the Yahoo! Groups interface for the group "tropnetfriends - TropNetEurop Friends & Observers". The page includes a navigation menu on the left with options like Home, Messages, Pending, Spam?, Delete!, Post, Attachments, Files, Photos, Links, Database, Posts, Members, Pending, and Calendar. The main content area features a "Management Tasks" section with a "1 Message Waiting For Approval" notification, an "Activity within 7 days: New Questions" section, and a "Description" section. Below the description is a "Mailing list for friends & observers of TropNetEurop" and a "Most Recent Messages" section. The messages listed are:

- Report in imported dengue fever**: Dear colleagues Attached comes our report on imported dengue in 2009. Best wishes Tomas Jelinek \*\*\*\*\* Dr. Tomas  
Posted - Tue Jul 6, 2010 2:44 pm
- Report on imported tertian and quartan malaria**: Dear colleagues Attached comes our latest report, with focus on imported tertian and quartan malaria. Best wishes Tomas Jelinek Berlin Center for Travel &  
Posted - Sat Jul 3, 2010 9:17 pm
- Report on imported falciparum malaria**: Dear colleagues Attached comes our report on imported falciparum malaria in 2009. Comments are most welcome. Best wishes Tomas Jelinek  
Posted - Tue May 4, 2010 9:05 pm
- Report on Malaria in 2009**: Dear colleagues Attached comes our final report on imported malaria in 2009. Details on different plasmodial species will follow with the next two reports.  
Posted - Mon Apr 20, 2010 11:29 pm
- Imported schistosomiasis in 2009**: Dear colleagues Attached comes our preliminary report on imported schistosomiasis. Comments are most welcome. Best wishes Tomas Jelinek  
Posted - Tue Jan 19, 2010 1:02 pm

On the right side, there is a search bar and a list of members, including Tomas Jelinek (jelinek30, jelinek@tropnet.info, jelinek050, jelinek050, jelinek050, jelinek050, jelinek050) with options to follow or send emails.

**Surveillance Questionnaire for Imported Infectious Diseases (TropNetEurop)**

(Fax to +49-30-36802844, att. Dr. T. Jelinek)

Clinic ID	Patient ID	Date Initial Visit (DD/MM/YY)	<input type="checkbox"/> Inpatient	Inpatient days	Sex	Date of birth (DD/MM/YY)
		/ /	<input type="checkbox"/> Outpatient		M   F	/ /
Country of birth	Country of residence	Citizenship	If born outside Europe, give date of first arrival			(DD/MM/YY)
						/ /

<b>HISTORY OF RECENT TRAVEL</b>		<b>Trip Duration (number of days)</b>	<b>Trip Ended (DD/MM/YY)</b>
List, in order, journeys to all countries relevant for this visit, and indicate most likely country of infection by checking			/ /
1. _____ <input type="checkbox"/>	4. _____ <input type="checkbox"/>		
2. _____ <input type="checkbox"/>	5. _____ <input type="checkbox"/>		
3. _____ <input type="checkbox"/>	6. _____ <input type="checkbox"/>		
<b>Detailed information on likely place of infection (town, area):</b>			
Pre-Travel counselling by health care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			
Malaria <input type="checkbox"/> None <input type="checkbox"/> Chloroquine <input type="checkbox"/> Proguanil <input type="checkbox"/> Mefloquine <input type="checkbox"/> Doxycycline <input type="checkbox"/> Atovaquone/Proguanil			
Chemoprophylaxis: <input type="checkbox"/> Other:		Compliant <input type="checkbox"/> Yes <input type="checkbox"/> ...No	

<b>Patient Classification</b>	<b>Reason for most recent travel</b>	<b>Chief complaint (CHECK ALL THAT APPLY)</b>
<input type="checkbox"/> Immigrant / Refugee <input type="checkbox"/> Foreign visitor <input type="checkbox"/> European, lives/works in Europe <input type="checkbox"/> European, lives/works outside Europe (urban) <input type="checkbox"/> European, lives/works outside Europe (rural)	<input type="checkbox"/> Tourism <input type="checkbox"/> Visiting Relatives/Friends (VRFs) <input type="checkbox"/> Business <input type="checkbox"/> Immigration <input type="checkbox"/> Research / Education <input type="checkbox"/> Missionary/Volunteer/Humanitarian <input type="checkbox"/> Military <input type="checkbox"/> Other	<input type="checkbox"/> Asymptomatic Screening <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Vomiting <input type="checkbox"/> ENT <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurologic <input type="checkbox"/> Psychologic <input type="checkbox"/> Other:
<b>Or:</b>		
<input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Skin <input type="checkbox"/> Respiratory <input type="checkbox"/> Headache		

Date of symptoms onset: (DD/MM/YY) / /

DIAGNOSIS AND TREATMENT	1. Notification Dx	2. Notification Dx	3. Notification Dx
Working Dx			
Final Dx			
How was Dx achieved? <sup>1</sup>	P D A SP M G C O	P D A SP M G C O	P D A SP M G C O
Treatment (1. drug)			
Treatment (2. drug)			
Treatment (3. drug)			
Treatment (4. drug)			

<sup>1</sup> Diagnostic Procedures: P=Pathogen detection D=DNA detection A=Antigen detection SP=Antibody increase in serum pair (IgM or IgG) M=IgM detection G= IgG detection C=Clinical reasoning O=Other

Accompanying Diagnoses: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

COMPLICATIONS?  Yes  No If Yes, which? \_\_\_\_\_DEATH?  Yes  No If Yes, why? \_\_\_\_\_

**TropNetEurop - Monitoring of Intravenous Artesunate Treatment in Patients with severe P. falciparum Malaria**

Fax together with surveillance report of same patient to +49-30-36802844, att. Dr. T. Jelinek. In case of electronic reporting, please fill in TropNet/SIMPID ID assigned by your Sentry Software.

<b>CLINIC ID</b>	<b>TropNet/SIMPID ID:</b> (Fill in, if malaria case has been reported electronically)	<b>Patient ID:</b> (Fill in, if malaria case has been reported on paper)
/ . . / : :		
<b>Pre-treatment criteria of severe malaria:</b>		
<b>Artesunate producer:</b>		<b>Artesunate batch number:</b>

<b>Treatment regimen including i.v. Artesunate:</b>	<b>First line Treatment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Date Day 1= Day of Dx and start of first line Tx (dd/mm/yy)</b> / /	<b>Body weight</b> kg		
<b>Administered anti-malarial substances</b>	<b>Start of administration</b>	<b>End of administration</b>	<b>Total dose</b>
Drug1: Artesunate i.v.	Day #	Day #	mg
Drug2:	Day #	Day #	mg
Drug3:	Day #	Day #	mg
<b>Was the treatment course completed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>if no, why</b>		
<b>Additional/Supportive treatment:</b>			

<b>Efficacy of i.v. Artesunate treatment regimen:</b>	<b>Duration of inpatient treatment:</b> days
<b>Parasitemia on day 1:</b> / $\mu$ l	<b>Parasite clearance time (Best estimate):</b> hours
<b>Temperature on day 1:</b> °C	<b>Fever clearance time (Best estimate):</b> hours
<b>Complications under treatment:</b> <input type="checkbox"/> None <input type="checkbox"/> Malaria-related complication <input type="checkbox"/> Treatment failure <input type="checkbox"/> Bacterial superinfection <input type="checkbox"/> Other	
<b>Complications - details:</b>	
<b>Outcome:</b> <input type="checkbox"/> Cure without residues <input type="checkbox"/> Cure with residues <input type="checkbox"/> Exitus on day	
<b>Outcome - details:</b>	

<b>Safety of i.v. Artesunate regimen:</b>	<b>Adverse drug reaction suspected?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>if yes, specify below</b>							
<b>Adverse drug reaction</b> (Please, fill in one line per suspected ADR)	<b>Day of onset</b>	<b>Day of resolut.</b>	<b>Severity at time point of maximum intensity</b>			<b>Relation with Artesunate</b>		
	Day #	Day #	mild, no specific medication needed	moderate, specific treatment needed	severe, disabling or life-threatening	No	Possible	Probable
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Other events of the past year:**

- New ECDC tender
- New dengue study

Swiss TPH



Swiss Tropical and Public Health Institute  
Schweizerisches Tropen- und Public Health-Institut  
Institut Tropical et de Santé Publique Suisse

Medicine and Diagnostics

# TropNetEurop 10

an attempted road map



Universität Zürich  
Institut für Sozial- und Präventivmedizin

Swiss TPH



## *TropNetEurop 10: Three main platforms*

1. Communication among members
2. Research
3. Policy development



## 1. *Communication among members*

### Interactive internet site:

- Discussion of special cases
- Structured short reporting of emerging and unexpected events and clinical cases, follow-up by coordination centre
- Support and teaching



## 1. *Communication among members*

### Interactive internet site:

- Discussion of special cases (prevention, diagnosis and treatment)



## 1. *Communication among members*

### Reporting:

- Stop present reporting system
- Short, real-time, web-based reporting platform of unusual medical problems and outbreaks observed in travellers (e.g. leprosy, amoebic liver abscess, typhoid fever), follow-up by coordination centre (e-mails & tel calls by coordination centre)
- Main focus: Emerging diseases surveillance

23. August 2010

TropNetEurop 10

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## 1. *Communication among members*

### Support and teaching

- Provision of handouts for travellers (and possibly for physicians) in major languages (English, French, German, Italian, Spanish, Dutch)

### Course info

Offer hands-on-training in larger partner centres for smaller units

- Practical syndromic differential diagnosis (e.g. fever, skin, eosinophilia)

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## 2. Research

- Develop and coordinate TropNetEurop into a research platform for different working groups around specific topics of travel medicine
- Take up topics suggested by constituency
- Focus on topics relevant to pretravel, during travel and post-travel medicine issues, based on experience of constituency

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TropNetEurop 10

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## 2. Research

### TropNetEurop Research Platform

#### **Goal: Evidence-based travel advice**

Network structures and expert-consultancy available at Swiss TPH and elsewhere

Financial independency from ,traditional' sponsors (e.g. submission to major grants, e.g. FP7, National Reserach Foundations)

23. August 2010

TropNetEurop 10

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## 2. Research

Methodology: which intervention where? Risk based on endemicity in host country or among travellers?

Non-communicable problems

- Cardiovascular events, (Road) accidents,

Communicable diseases

- Prevention, diagnosis und management: e.g. Leishmaniasis, Giardiasis, Vivax-malaria; post-marketing surveillance of vaccines

Risk behaviour communication



## 3. Policy development

Step-by-step approach (,baking small breads):

- Where do countries agree already?
- Which topics need ,the last push' for consensus
- Interaction with EuroTravNet, WHO, CDC etc.
- Malaria and other vector-borne diseases recommendations



### *3. Policy development*

„Expert Committee for Travel Medicine“ as possible nucleus for the „European Recommendation Initiative based on Common sense“ (ERIC)

=> **Harmonisation of expert recommendations**



### *3. Policy development*

**Strengthening non commercially interested national and international relationships in research, teaching and services**

Establishing and further developing relations with networks such as ENVID, FESTMIH, ISTM and Organizations (WHO, CDC, NESTM, EuroTravNet)

Joint Course on Travel medicine at different sites („European ISTM Prep Course“)



## Output 2011: *Three main platforms*

1. „Active“ internet platform. 10 Handouts available in E, F, G and S
2. Two research projects running
3. Minimal agreement of travel advice; Meeting on European Recommendations for Travel Medicine between TropNetEurop and EuroTravNet

## Election of coordinator and steering committee

Current coordinator:

- Tomas Jelinek, Berlin

Current steering committee members:

- Ron Behrens, London
- Zeno Bissoffi, Verona-Negrar
- Joaquim Gascon, Barcelona
- Tomas Jelinek (ex officio)
- Leo Visser, Leiden

Candidates for coordinator

- Christoph Hatz, Basel

Candidates for Steering Committee

- Ron Behrens, London
- Joaquim Gascon, Barcelona
- Martin Grobusch, Amsterdam
- Tomas Jelinek, Berlin
- Leo Visser, Leiden

**New coordinator**

- **Christoph Hatz, Basel**

**New Steering Committee**

- **Ron Behrens, London**
- **Joaquim Gascon, Barcelona**
- **Tomas Jelinek, Berlin**
- **Leo Visser, Leiden**

### **TropNetEurop Meeting in 2011**

- Discussion of venue, date and local organiser
- Proposition by Jiri Beran: Prague, SEP 3-4

**PRESENTATIONS**  
**SATURDAY, 28<sup>TH</sup> AUGUST 2010**

**Newer diagnostic approaches to intestinal and helminthic parasites**

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Lisette van Lieshout, Leiden

No abstract available

## S-E Asia study

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Ron Behrens, London

No abstract available



## **Malaria Diagnostics, the next generation**

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Peter Chiodini, London

No abstract available

## Artesunate and the TropNet Severe Malaria Study – Retrospective or Prospective ?

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Thomas Zoller, Berlin

Artesunate has become in several TropNet centres an important treatment alternative for severe malaria. Although the problem of availability has been solved, questions about efficacy and safety of the drug, not manufactured according to GMP standards, remain. A definitive date for commercial availability of GMP-Artesunate is still not known. A first case series from Norway published by the TropNet Bergen Centre showed an excellent efficacy of artesunate.

A second case series with 25 patients from 7 centres equally shows good efficacy but in 6 patients from five different centres, an unusual episode of intense, but self-limiting haemolysis in the second week after parasitological cure was observed. This observation underscores the need for a systematic data acquisition in a study with prospective design. Due to the low case numbers in a single center, TropNet provides an excellent platform for multi-center studies and one of the few possibilities worldwide to study the pathophysiology and treatment of severe malaria outside endemic areas. Possibilities to implement a prospective Artesunate study will be discussed in the presentation.

## **MALTHER Study**

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Martin Grobusch, Amsterdam

No abstract available

## **Presentation of the new Dengue research protocol**

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Leticia Franco, Madrid

No abstract available

## Evidence for a revised dengue case classification: a multi-centre prospective study across Southeast Asia and Latin America

Thomas Jänisch<sup>6</sup>, Angel Balmaseda<sup>1</sup>, Ivo Castelobranco<sup>2</sup>, Efren Dimaano<sup>3</sup>, Tran Tinh Hien<sup>4</sup>, Nguyen Thanh Hung<sup>5</sup>, Axel Kroeger<sup>7</sup>, Lucy Lum<sup>8</sup>, Eric Martinez<sup>9</sup>, Joao Bosco Siqueiera<sup>10</sup>, Tran Thi Thuy<sup>11</sup>, Iris Villalobos<sup>12</sup>, Elci Villegas<sup>13</sup>, Bridget Wills<sup>14</sup>

On behalf of the European Union - World Health Organization (WHO-TDR) supported DENCO Study Group:-

### Affiliations

1 - Departamento de Virología, Centro Nacional de Diagnóstico y Referencia, Managua, Nicaragua; 2 - Universidade Federal de Ceará, Fortaleza, Brazil; 3 - San Lazaro Hospital, Manila, Philippines; 4 - Hospital for Tropical Diseases, Ho Chi Minh City, Vietnam; 5 - Children's Hospital No.1, Ho Chi Minh City, Vietnam; 6 - Section of Clinical Tropical Medicine, University Hospital of Heidelberg, Germany; 7 - Special Programme for Research and Training in Tropical Diseases, TDR-World Health Organization, Geneva, Switzerland; 8 - Department of Paediatrics, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia; 9 - Instituto Pedro Kouri, La Habana, Cuba; 10 - Universidade Federal de Goiás, Goiania, Brazil; 11 - Children's Hospital No.2, Ho Chi Minh City, Vietnam; 12 - Hospital Central de Maracay, Venezuela; 13 - Universidad de los Andes, Nucleo Trujillo, Venezuela; 14 - Oxford University Clinical Research Unit, Ho Chi Minh City, Vietnam

**Background:** There has been growing concern regarding the applicability and usefulness of the current World Health Organisation (WHO) classification system for dengue. The terminology emphasises haemorrhage rather than vascular leakage as an indicator of severity, and the classification is misleading in a significant proportion of patients with shock.

**Methods:** We recruited children and adults with suspected dengue in seven countries across Southeast Asia and Latin America. Patients were followed daily with detailed case report forms, and subsequently categorised into one of three intervention groups according to the overall level of medical and nursing support required. Using an *a priori* analysis plan, the clinical and laboratory profiles characteristic of these intervention categories were explored to develop a revised system based on disease severity.

**Results:** 2259 patients were recruited between August 2006 and May 2007. A total of 230 (13%) of the 1734 laboratory confirmed patients required major intervention, with approximately 5% of patients progressing to this level of severity in hospital. Applying the current WHO system, 47/210 (22%) of patients with shock did not fulfil all criteria necessary for dengue haemorrhagic fever. Inclusion of readily discernible complications (shock and/or severe bleeding and/or severe organ dysfunction) was necessary in order to devise a (binary) revised system that identified patients requiring major intervention with sufficient sensitivity and specificity to be practically useful. A three-tier system was investigated, but did not yield satisfactory results in terms of sensitivity and specificity. Several warning signs for disease progression could be empirically validated. The need to identify a subgroup of patients with warning signs requiring frequent monitoring is discussed.

**Conclusions:** Based on these results, a revised classification system comprised of two entities, "Dengue" and "Severe Dengue", is proposed.

## Imported mycoses: neglected and unrecognized: French data

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Michel Develoux, Paris

Imported mycoses in Europe are mainly but not exclusively contracted in tropical areas. These mycosis can be superficial such as tinea capitis and scytalidiosis. Nowadays in France tinea capitis is mainly due to anthropophilic species (*Microsporum langeronii*, *Trichophyton soudanense*) and involves children of African origin. Scytalidiosis is observed in migrants from West Indies and sub-Saharan Africa. Its clinical manifestations are similar to those of *Trichophyton rubrum* dermatophytosis.

Concerning subcutaneous infections, eumycetoma and actinomycetoma are diagnosed sporadically; most of the patients come from Mali or Senegal two countries situated in the African “mycetoma belt”.

*Histoplasma capsulatum* var *capsulatum* histoplasmosis is the most frequent imported systemic mycosis diagnosed in France. It must be pointed out that France has overseas territories where histoplasmosis is endemic, principally French Guiana but also French West Indies and New Caledonia. Nearly 25% of imported histoplasmosis cases have been contracted in French Guiana. From 2002 to 2008, 124 cases of histoplasmosis were declared to the “Centre national de reference des mycoses et antifongiques”, institut Pasteur, Paris, 70 of them were HIV-infected patients.

Concerning the 54 sero-negative patients, 35 had an acute or subacute form after a recent exposure. African histoplasmosis, due to *H capsulatum* var *duboisii*, is rare (1 case per year), observed in sub-Saharan migrants or in Europeans who lived for long periods in endemic areas.

Coccidioidomycosis is an emerging imported mycosis in Western Europe. First imported paracoccidioidomycosis were recently reported in France. *Blastomycoses dermatitidis* and *Penicillium marneffeii* infections are exceptionally observed.

It is important to insist on the danger of manipulation of *Histoplasma capsulatum* and *Coccidioidomyces immitis* cultures for microbiologists with the possibility of laboratory contaminations.

## **Tropical Medicine in Amsterdam**

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Martin Grobusch, Amsterdam

No abstract available

## The Faculty of Travel Medicine

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Peter Chiodini, London

No abstract available



SUNDAY, 29<sup>TH</sup> AUGUST 2010**Melioidosis imported from West Africa to Spain**

Juan Cuadros Gonzales, Alcalá - Madrid

*Burkholderia pseudomallei* infections are an important cause of systemic pyogenic disease associated with high mortality in South East Asia and northern Australia. In the last two decades, however, there have also been increasing reports of confirmed locally acquired cases and small outbreaks in America (specially Brazil) and some African countries. Although sporadic cases of melioidosis have been reported from West and East Africa and, more recently, from Madagascar and Mauritius, the extent and relevance of this disease in the continent remains largely unknown probably because the absence of bacteriological diagnostic resources. Also, the overlapping of the clinical disease caused by *B. pseudomallei* with other pyogenic infections, such as tuberculosis, and the lack of awareness of the disease amongst clinicians could explain the blank data on this continent. From Gambia, only one previous case report of melioidosis has been published back in 1983.

We report here what seems to be the first case of imported melioidosis in Spain in a diabetic patient who visited during five months Gambia, from where he returned with fever, bilateral calf abscesses and splenic and pleural microabscesses. Due to the exceptional presentation of this disease in Africa, clinical and microbiological diagnosis of imported melioidosis from this continent can be very elusive.

Although infections acquired after laboratorial exposure are rare and human-to-human respiratory transmission is not documented for *B. pseudomallei*, the isolation of a bacteria included in the list of bioterrorism agents which could produce a deadly disease prompted an intensive approach to chemoprophylaxis in our hospital. However, none of the 30 health and laboratorial personal who worked with the microorganism or the patient seroconverted. The molecular characterization of the strain showed a strong affinity with an isolate from Martinique, which suggests a possible relation with the established trading posts in the French colonies during the XVII-XIX centuries.

***Loa Loa* ocular filariasis: possible emergence in Europe of a neglected disease ?**

Spinello Antinori, Laura Galimberti, Giuseppe Giuliani

Department of Clinical Sciences L Sacco, Section of Infectious Diseases and Immunopathology  
Post-Graduate School of Tropical Medicine, University of Milano, Italy

**Background-** *Loa Loa* is a filarial nematode found in the rainforests of western and central Africa transmitted by tabanid flies belonging to the genus *Chrysops*. Loiasis is also known as the “African eye worm” because the adult worm can sometimes be seen migrating under the conjunctiva of the eye where it causes injection, itching and photophobia. Loiasis can also be associated with the so called “Calabar swellings” that are subcutaneous oedemas seen more frequently on the limbs especially among expatriates. Diurnally periodic microfilariae appear in the blood after a prepatent period of 6-12 months.

**Case reports-** We report here two cases of ocular loiasis observed during the last year in two African women living in Italy; moreover, we have reviewed all published cases of imported ocular loiasis since 1988.

Case 1- A 27-year-old female originating from Cameroon presented to the emergency department in July 2009, complaining of “foreign body sensation” in her left eye lasting for several hours. A yellowish worm-like was seen moving in the inferior fornix and a provisional diagnosis of “ocular loiasis” was made. Blood examination showed microfilariae identified as *Loa Loa*. She was 16 week pregnant and we decided to follow-up and treat her after delivery. She delivered a normal female baby in January 2010. Microfilariae were identified in the placenta but blood cord and baby’s blood were both negative. She was treated with two cycle of ivermectin (one month apart) and 4 weeks of albendazole (after stopping breast-feeding) without disappearance of blood microfilariae. At the time of writing a 21-day treatment with diethylcarbamazine (DEC) kindly provided by Dr Daumerie and Dr Reggi (Department of Control of Neglected Tropical Diseases, WHO) is ongoing.

Case 2- A 25-year-old African girl from Cameroon presented to the ED in May 2010 complaining of pruritus, burning and foreign body sensation in her left eye that date back from the day before. On ophthalmological examination a translucent, coiled and motile worm was visualized subconjunctivally in the lower temporal quadrant of the eye; blood examination was negative for the presence of microfilariae. She was treated with a single dose of ivermectin (200µg/kg) followed by 21-day of DEC. In the short follow-up there was no recurrence.

**Conclusions-** Loiasis is highly endemic in Cameroon where in some villages near 47% of adult residents have detectable microfilariae in blood. During a 1-year period in Milano (Italy), we observed two immigrant African women stably living in our country that presented to ED with ocular loiasis. Both cases were initially misdiagnosed. From 1988 up to 2010, we retrieved from medical literature 26 cases of imported ocular loiasis (two cases from India were excluded). Seventeen were in immigrants and 9 in expatriates and tourists. Six cases were published from 1988 to 2002 and twenty from 2002 to 2010. Sixty-one% of cases were reported from Europe and we speculate of the possible emergence of ocular loiasis especially in those countries such as France, Germany, UK and Italy where there is high immigration from Cameroon. Since the analysis of the literature shows that patients affected by *Loa loa* are treated in different ways we will try to discuss what is the best clinical management of this disease.

## Cystic echinococcosis, an orphan disease in Europe

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Peter Chiodini, London

No abstract available

**Acute schistosomiasis in a cluster of travellers from Rwanda: diagnostic contribution of qualitative schistosoma DNA detection in serum compared to parasitology and serology**

Jan Clerinx<sup>1</sup>, Emmanuel Bottieau<sup>1</sup>, Dominic Wichmann<sup>2</sup>, Egbert Tannich<sup>2</sup>, Marjan Van Esbroeck<sup>1</sup>

1. Department of Clinical Sciences, Institute for Tropical Medicine Antwerp

Nationalestraat 155, B-2000 Antwerp, Belgium

2. Bernhard-Nocht Institute for Tropical Medicine, Hamburg, Germany

**Introduction:**

Diagnosis of acute schistosomiasis is often elusive in travellers. The clinical and diagnostic features including qualitative schistosoma DNA detection, of primary and secondary schistosomiasis are described in a cluster of 13 travellers infected in Rwanda.

**Patients and methods:**

Acute schistosomiasis was suspected in 13 Belgian children and adults, after swimming in the Muhazi Lake, Rwanda. All were subjected to clinical examination, eosinophil count, feces parasite detection, schistosoma antibody tests (ELISA and IHA), and schistosoma DNA detection in serum by polymerase chain reaction (PCR).

**Results:**

All 13 patients, between 6 to 29 years old, had a high eosinophil count (median 2120/ $\mu$ l; range 1150-14270). Seven out of 9 persons with primary infection developed symptoms compatible with Katayama syndrome. Eggs of *S.mansoni* were found in a concentrated feces sample of 9/13 (69%), with low egg counts (median 20 eggs per gram; range 10-120). Antischistosoma antibodies (ELISA and/or IHA) were present in serum of 10/13 (77%) patients. Combining serology and fecal examination demonstrated schistosomiasis in 11/13 (85%) patients. Schistosoma specific DNA was present in 13/13 (100%) serum samples.

**Conclusion:**

In this cluster of travellers, schistosoma DNA detection in serum was able to confirm infection in all exposed persons. To confirm schistosomiasis in its acute phase, it clearly outperformed antibody tests and parasite detection methods.

**Katayama fever: presentation of two cases with lung involvement and discussion of treatment**

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Jose Muñoz, Madrid

No abstract available

**Rabies vaccine study**

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Ron Behrens, London

No abstract available

**Hepatitis B & Schistosomiasis co-infection**

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Matthias Schmid, Newcastle-upon-Tyne

No abstract available