An Occasional Medical *Newsletter* from The Blood Care Foundation

Dear Member,

It is now 6 months since the Twin Towers disaster, but, just because nothing further has happened, we must not drop our guard. I have been giving a series of lectures entitled "Blood does not grow on trees", in which I describe the areas to be covered in a disaster plan and emphasise the need for this to be regularly exercised and updated. In fact you can modify the audit cycle to test your disaster plan. Draw up the plan, exercise it, identify the problems, revise the plan and then go round the circle again. It would appear, from the item below, that I have not been a lone voice crying in the wilderness.

Emergency Preparedness.

Following the attack on the Twin Towers, the Chief Medical Officer reviewed the Department's ability to thwart a terrorist threat and decided to improve the preparedness. A DH Operations room was established and a team from the Department, with staff seconded from the NHS, PHLS and other expert and specialist bodies, firstly prepared guidance for clinicians in responding to a physical threat. They then turned to dealing with chemical, biological, radiological and nuclear threats. Current surveillance systems have been strengthened and new methods are being investigated. Further information can be obtained from Dr Bruce Court (Bruce.Court@doh.gsi.gov.uk) or from the following websites. http://emergencynews.ukonline.gov.uk/contingency/anthrax.htm, http://www.phls.co.uk/facts/deliberate_releases.htm and http://www.bt.cdc.gov.

Health Information for Overseas Travel.

A revised copy of Health Information for Overseas Travel, to replace the 1995 edition, is now available on the Internet at http://www.the-stationery-office.co.uk/doh/hinfo/index.htm. It will be regularly updated. Advice on air travel and DVT is available at http://www.doh.gov.uk/dvt.

Travellers' Diarrhoea.

We are all well aware of the disruption Travellers' Diarrhoea can cause to a business trip or holiday. A recent supplement to the Journal of Travel Medicine provides an excellent review of the epidemiology and treatment of this problem, together with an evaluation of a new drug, rifaximin, in its treatment. (*J.Trav.Med.* 2001;**8(Suppl 2)**:S25-40)

Cervical Cord Injuries.

A recent survey has found that failure to properly immobilise patients at risk of cervical cord injuries, is far from uncommon. Such failure can have devastating effects as 75% of injuries to the spinal cord are incomplete at the time of presentation. Skellett and colleagues found that not only was there a failure to immobilise properly at the time of presentation, but patients were given the all clear before they had been properly evaluated. In their survey of 60 children, they found 14 cases where immobilisation prior to transportation was inadequate. They recommend better training of healthcare professionals with regard to immobilisation of potential cervical injuries and better provision of immobilisation devices that are appropriate to different age groups. (*BMJ.* 2002;**324**:591-3)

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Hay Fever.

A recent randomised, double blind trial has shown that the herbal medicine, butterbur (*Petasites hybridus*) is as effective as cetirizine, an antihistamine, in the treatment of seasonal allergic rhinitis (hay fever). Butterbur had the added advantage that it has no sedative effects. (*BMJ*. 2002**;324**:144-6)

Women's Health.

A recent study from Duke University, Durham, North Carolina has shown that oral contraceptives with a higher progestogen potency give better protection against ovarian cancer than those with lower levels. Another study showed that women, in whom the human papillomavirus persists for several months, have a greater risk of developing cervical cancer than in those who quickly clear the infection. (*J.Nat.Cancer Instit*. 2002;**94**:32-6 and *JAMA*. 2002;**286**:3106-14)

Yellow Fever Vaccination.

There have been a number of reports recently, which have questioned the safety of the current 17D yellow fever vaccine. There have been 10 cases where people vaccinated against yellow fever have developed an illness resembling classic yellow fever and, in 6 cases, the patients died within 2 weeks. As the vaccines came from at least 3 different manufacturers, reversion to a wild strain is highly unlikely and it must be presumed that we are becoming aware, after 50 years of use, that some people have an idiosyncratic host susceptibility to the vaccine. In a thoughtful editorial, Philip Mortimer, who is the Director of the ST & BBV Division of the Central Public Health Laboratory, points out that the risk of catching yellow fever far outweighs any danger posed by the occasional idiosyncratic response. (*BMJ.* 2002;**324**:439)

The Viral Haemorrhagic Fevers.

Jane Weaver gives an interesting insight into the history of Yellow Fever in an article, which follows an excellent review on the viral haemorrhagic fevers. Pauline MacDonald and Andy Green examine the general perception of these diseases, which are that they are rare, difficult to acquire and have a high fatality rate. The truth is actually the reverse of our perception. The diseases are relatively common, for instance there are about 300,000 cases of Lassa Fever in West Africa every year. If you travel to the endemic areas and live in relatively poor surroundings, they are not difficult to acquire via insect and/or rodent bites, although person-to-person transmission is relatively uncommon. Cases transferred to Europe have a high fatality rate because of delays in diagnosis and/or treatment, but in 2000, all cases of Lassa Fever in UN peacekeepers in Sierra Leone survived without serious sequellae. This is probably due to their excellent nutritional state and early diagnosis and treatment. This is an invaluable article as it puts our perceptions of these diseases into perspective and emphasises the need for prevention and early diagnosis. I would strongly advise anyone in the H&HR field to read this. (*Travel Wise.* 2002;**10**:3-4)

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