

An Occasional Medical *Newsletter* from The Blood Care Foundation

Dear Member,

It was just over 7 years ago that I tentatively penned the first of these occasional newsletters and here we are at the half-century. This has caused me to consider this period and, as far as the traveller is concerned, there appear to be 4 major changes. Firstly, travel medicine has become recognised as a specific speciality. This has led to the formation of specialist societies, such as the British Travel Health Association, and a greater availability of expert advice and treatment, both preventative and operative, for travel related health problems. Secondly, in spite of 9/11, more people than ever are travelling to more remote destinations. The third change is the emergence of international terrorism as a real problem, well illustrated by the recent attacks in Turkey. Such attacks put a massive strain on the medical services and frequently exhaust the local bloodstocks.

Finally, there has been the emergence of HIV as a global disaster as described recently by Stabinski et al and Mukherjee et al (*BMJ*. 2003;**327**: 1101-3 & 1104-6). The problems for the traveller is more widespread than you would at first imagine. Yes, you can ensure that you do not put yourself at risk by taking part in risky practices, but there are also factors beyond your control. In my last letter I mentioned the problems associated with the re-use of disposable syringes and needles, but a couple of days ago I was reminded of an even greater risk.

At the speakers' dinner at the international meeting of the Intensive Care Society, I was sitting next to a South African surgeon who practices in the main teaching hospital in Johannesburg. He told me that it is becoming increasingly common to be called by the transfusion centre to be informed that a donor, whose blood he had transfused a couple of weeks earlier to a patient, had now been found to be positive for HIV. He went on to say that the number of donated units, which are in the "window period", is now approaching 1 in 3,000.

Apart from the increasing risk of receiving an infected unit of blood, what does this information tell us? It warns us that in any particular country, although the front-line services, such as surgery and medicine, may be excellent, safety also relies on the quality of the support services such as those provided by the blood bank. It only goes to emphasise that each year the Foundation is becoming more relevant to travel health. Finally, if you are interested in the lessons that we learnt from 9/11 and from all the other major disasters since the WWII, you might like to read the article by John Hess and myself, with the cover illustrations, published in the November edition of *Transfusion* (*Transfusion*. 2003;**43**(11):1622-33). If you cannot get hold of a copy, I am sure I could e-mail you a reprint.

Unexplained Fever in Young Children.

Fever with no clear source of infection in children under 3 years old carries a small but important risk of sepsis and meningitis. Itzhak Brook (*BMJ*. 2003;**327**:1094-7) has produced an excellent review of the bacterial causes of such infection and the appropriate management in different age groups. Whereas most young children with fever but no focus of infection have a self-limiting viral infection, those under 1 month should be treated with antibiotics and all those less than 7 days old should be admitted to hospital. Premature babies are at much greater risk. Children with the following criteria are unlikely to have a serious bacterial infection:

- ✂✂ No clinical evidence of infection of the ear, skin, bones or joints.
- ✂✂ White blood cell count between 5 and 15 x 10⁹/l.
- ✂✂ Fewer than 1.5 x 10⁹ band cells/l.
- ✂✂ Normal urine analysis.

Sun Exposure and Multiple Sclerosis.

Just when we thought we had heard everything there was to hear about exposure to the sun, van der Mei and colleagues come up with another idea. They reviewed 136 patients suffering from multiple sclerosis and 272 age matched controls. They found that people who had been exposed to more than 2 hours sunshine per day in the summer at weekend and holidays, when aged 6-15 years, were up to a third less likely to develop multiple sclerosis than those who had had less than 2 hours exposure. (*BMJ*. 2003;**327**:316-20)

Antibiotics and Sinusitis.

In a randomised double blind trial, 252 adult patients, with a history of purulent nasal discharge and maxillary or frontal sinus pain for at least 48 hours, were treated with a nasal decongestant plus either co-amoxiclav (amoxicillin/clavulanic acid) or placebo. There was no difference in the cure rates between the 2 groups, but those treated with the antibiotic were 4 times as likely to suffer from diarrhoea. (*Arch.Intern.Med*. 2003;**163**:1793-8)

MMR, Autism and a Measles Epidemic.

Dr Simon Murch, one of the authors of the original article postulating a connexion between the MMR vaccine and autism (*Lancet*. 1998;**351**:637-41), in a recent letter has warned that, unless children do not have the MMR vaccine, there is a definite risk of a major measles epidemic with associated mortality and major morbidity. He stated "There is now unequivocal evidence that MMR is not a risk factor for autism". (*Lancet*. 2003;**362**:832)

NSAIDs in Pregnancy, for and against.

A recent meta-analysis has shown that low dose aspirin protects women who are at risk of pre-eclampsia. Average birth weight was higher in the aspirin group and there was no evidence of increased bleeding complications. On the other hand women, using non-steroidal anti-inflammatory drugs, including aspirin for pain control, around the time of conception or during early pregnancy had an 80% increase in the chance of miscarriage, when compared to those who took paracetamol. (*Obstet.gynecol*. 2003;**101**:1319-32 *BMJ*. 2003;**327**:368-74)

Duration of Illness in Children.

Doctors frequently tell carers that children with suspected acute upper respiratory tract viral infections will get better very quickly. Butler and colleagues, in a randomised trial found that less than half the children recovered in 4 days, more than a quarter were still ill after a week and 6% had not recovered at the end of a fortnight. The message is that doctors should give carers this information so that they will not be worried if the infection does not regress dramatically, thereby reducing worry and further consultations. (*BMJ*. 2003;**327**:1088-90)

Cannabis and Multiple Sclerosis.

The 3-year CAMS (cannabis in multiple sclerosis) trial, involving more than 600 patients has shown no evidence that cannabis, either as whole extract or tetrahydrocannabinol (THC), the drug's principal active ingredient, eases the symptoms of spasticity in MS. (*Lancet*. 2003;**362**:1517-26)

Monday, 08 December 2003

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