Health Overseas for Adventure Racers

Article by Jean Sinclair

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Adventure Racing and Health

Adventure racers, like most people who participate in outdoor activities, competitively or not, are usually skilled in preventing and treating many health problems, so this article is not going to cover the sorts of problems that can happen anywhere or that are dealt with by standard first aid courses. It is intended to highlight topics UK adventure racers might need to consider before, during and after travelling overseas. This does not just mean in developing countries – for example, an infection little known in the UK, tick borne encephalitis, is present in many central and eastern European countries.

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Testing blood for malaria in Costa Rica

Advice on vaccinations and malaria

Consult a Practice Nurse at your GP surgery at least 28 days before travel, but preferably at least two months – this allows time for a series of vaccinations, and for them to become fully effective before travel. Remember that there can be a delay of up to 2 weeks before an appointment is available. If a full initial course of Hepatitis B and / or rabies is required, a series of 3 visits over a 21 to 28 day period will be needed.

It is useful to take any vaccine record books or cards you have to all appointments so that your requirements can be planned and additional vaccinations and reminders for booster dates can be recorded.

Certain vaccinations are “contraindicated” (definitely not suitable) for certain people eg young children (sometimes paediatric versions are available), old people, those who are immunocompromised (by illness or treatment), have thymic disease, are pregnant or breastfeeding (admittedly unusual among adventure racers) or are allergic to eggs or other components of vaccines. So, any decisions about vaccinations need to be made in combination with a health care professional, considering all the risks to be faced and potential benefits of vaccination.

However, as adventure racers usually know some months in advance if their application for a place has been successful, they can consult further in advance. Most people do not experience any major problems following vaccination, but competitors may prefer not to run the risk of a sore arm or malaise immediately before competition, examinations or important meetings or interviews.

Some private travel clinics offer evening and weekend appointments, which might be helpful for fitting around training or work schedules. Not all GPs or practice nurses can offer all vaccinations, and they may charge for some. However, vaccinations against hepatitis A, polio and typhoid should be free under the NHS.

Yellow fever vaccination can only be given at internationally approved centres – click here - for your nearest clinic. Japanese encephalitis and tick borne encephalitis vaccinations, in particular, are only available at certain specialist centres.

Japanese B Encephalitis is carried by mosquitoes associated with pigs or storks and paddy fields

Vaccinations available (in alphabetical order)

All schedules described are for adults, as recommended in the UK, and are liable to change. Day 0 means the first injection day of the schedule. Generally, intervals between vaccinations can be extended, but not shortened. Also, if there is insufficient time for an initial course, even one or two injections will offer some protection. The course can be completed on return, ready for future travel.

Cholera: Food / water / faecal borne infection.
A new oral vaccine, which is drunk, rather than injected, called Dukoral, became available in the UK on 12th May 2004. An initial course of 2 doses, 1 to 6 weeks apart, must be completed 7 days before travelling to a risk area, then boosters are needed every 2 years. Eating and drinking should be avoided for 1 hour before and 1 hour after vaccine. Vaccination should be considered for travel to most countries outside Europe, North America and Australasia. Dukoral also offers some protection against some forms of travellers' diarrhoea, although it is not licenced for this.

Diphtheria: Droplet borne infection.
Diphtheria vaccinations are given to UK babies, preschoolers and teenagers, in combination with other vaccines. A single diphtheria vaccine for adults is no longer available, only combined with tetanus. Booster required every 10 years.

Hepatitis A: Food / water / faecal borne infection.
1 injection gives instant protection; a booster 6 to 12 months later gives at least a further 10 years protection – probably 20 to 25 years. Combined Hepatitis A and Hepatitis B or Hepatitis A and Typhoid are also available. Vaccination required for travel to most countries outside Europe, North America and Australasia.

Hepatitis B: Blood borne infection.
Several initial schedules are available: Primary course of 3 injections, at day 0, then 28 days later and 6 months after the first or days 0, 28 and 56, then 1 year or days 0, 7, 21 and 1 year. A blood test to check antibody levels or booster is offered every 5 years. Approximately 5 to 10% of healthy individuals are "non responders", who do not produce adequate levels of antibodies in their blood. Hepatitis B vaccination is part of the national schedules of many countries in Europe and North America, but not the UK. Certain professional groups are offered protection in the UK. A combined Hepatitis B and Hepatitis A vaccine is available.

Influenza: Droplet borne infection.
Not specifically for travel, but adventure racers may wish to consider having a flu jab at the start of the winter season, to prevent losing training time. Vaccines are offered by the NHS to people on the basis or medical needs / risks. Some employers provide flu vaccines to certain employees. Some travel clinics offer flu vaccines to other people. Japanese B Encephalitis: Insect borne infection. A primary course of 2 injections, on day 0 and then 7 or 14 days later (preferably at least 10 days before travelling to risk area), then a booster after 1 year, then 3 yearly boosters. Vaccination is recommended for travel in rural areas of some countries of South East & East Asia, particularly where there are paddy fields and pigs or storks.

Measles / Mumps / Rubella: Droplet borne infections.
Depending on their age and sex, some UK adults may have had neither the necessary vaccinations nor exposure to infection to be protected. It is worth checking with GP / practice nurse to establish your status, and consider having vaccination(s) if required.
Meningitis ACWY: Droplet borne infection. UK children and teenagers are vaccinated against strains A and C only. 1 ACWY vaccination gives 5 years protection. Vaccination against ACWY is recommended for travel to some sub Saharan African countries, plus Moslem pilgrims to Mecca and other places in case of outbreaks.

Polio / Poliomyelitis: Food / water / faecal borne infection.
An oral vaccine (drops directly on tongue or on sugar lump) was given to UK babies, preschoolers & teenagers, along with tetanus & diphtheria jabs. This has now been replaced by an injection combining the 3 vaccines - boosters are required every 10 years.
Rabies: Infection carried in mammal saliva, spread by bites or licks. The best protection is offered by a primary course of 3 intramuscular injections on days 0, 7 and 21 or 28, followed by boosters every 2 to 3 years. Appropriate first aid, followed by swift transport to medical attention, including extra injection(s), is vital after being licked or bitten by a suspect mammal. Intradermal injections can also be very effective, if given by a skilled practitioner, but are not currently licensed in the UK.

Tetanus: Infection caused by organism in the soil.
Tetanus vaccinations are given to UK babies, preschoolers & teenagers, in combination with other vaccines. A booster is required every 10 years. There is some debate about how many jabs in total give lifetime protection against tetanus. A booster of tetanus vaccine or immunoglobulin may also be given after a deep wound.

Tick Borne Encephalitis: Tick borne infection.
A primary course of 2 injections, 21 days to 3 months apart, then third dose 5 to 12 months after the first, then a booster every 3 years; recommended for off the beaten track travel, including AR, orienteering, camping etc in parts of Central & Eastern Europe, Scandinavia, Central Asia. Vaccination against TBE is part of the national schedule of many European countries.

Tuberculosis: Droplet borne infection.
Routine vaccination of all UK teenagers ended in September 2005. 1 dose of BCG (Bacillus Calmette-Guerin) is considered to offer protection from 6 to 8 weeks post vaccination for 10 to 15 years. However, some studies suggest that no further protection is gained from booster vaccinations. If a person presents too late for vaccination to be effective and for vaccination site to heal (this vaccine, unlike others, may cause a small ulcer), they may be offered a tuberculin skin test (TST) before travel and 1 to 2 months after returning, to identify an infection. Typhoid: Food / water / faecal borne infection. A single dose of vaccine gives 3 years protection. Vaccine should be given at least 2 weeks before travel to a risk area. A combined Typhoid and Hepatitis A vaccine is available. Vaccination should be considered for travel to most countries outside Europe, North America and Australasia.

Yellow Fever: Insect borne infection.
1 injection, gives cover from 10 days after the injection for at least 10 years. A vaccination certificate, valid from 10 days after vaccine for 10 years, is required for entry to some countries in Africa and South America, and for entry to some Asian countries if travelling direct from Africa or South America.

Malaria – The ABCD of malaria management

A – Be aware when and where there is a risk, however small

B – Keep mosquito bites to a minimum

C – Use chemoprophylaxis (tablets / medication) properly

D – Report any feverish illness promptly to a doctor and say you have been in a malarious area

A – Be aware when and where there is a risk, however small
There are four types of malaria that affect humans, all carried by Plasmodium parasites: Plasmodium falciparum (causes malignant malaria, the most serious type), P. vivax, P. ovale and P. malariae. Not all parasites are present in all locations, and the risk of contracting malaria also varies through the year – usually highest during and soon after the rainy season. Malarial carrying mosquitos do not like cold or high altitude – malarial is not usually contracted above 1500m.

B – Keep mosquito bites to a minimum
Keeping all insect and tick bites to a minimum, not just those of night flying, malaria carrying mosquitoes, helps prevent many infections, including some such as dengue fever, for which there is no vaccine, nor specific treatment. The main techniques / equipment are covering skin with clothing (also helps in preventing sunburn), using insect repellents (DEET diethyl M-toluamide is the most reliable) and sleeping / sitting under mosquito nets between dusk and dawn.

C – Use chemoprophylaxis (tablets / medication) properly
The main drugs used by travellers from the UK are: chloroquine, proguanil (Paludrine), mefloquine (Larium), doxycycline, and proguanil with atovaquone (Malarone). Drug names starting with lower case letters are generic names, while those starting with capital letters are trade names, specific to one company. Names may be different in different countries, and different drugs and regimes are licensed / used in different countries. No single drug or regime is suitable for all destinations and all travellers. In some areas, parasites have become resistant to certain drugs, especially chloroquine.

Costs vary, but should never be the deciding factor: cover for two weeks in a malarial area costs about £18 for chloroquine and proguanil (Paludrine), £28 for mefloquine (Larium), £26 for doxycycline and £80 for proguanil with atovaquone (Malarone). NHS GPs may make a charge for writing a private prescription for malaria prophylaxis. Costs vary between chemists, both high street and internet, so it is worth looking around before using the prescription. Chloroquine and proguanil (Paludrine) can be bought over the chemist's counter without prescription.

Chloroquine and mefloquine (Larium) are taken weekly, but proguanil (Paludrine), Malarone and doxycycline are taken daily. Most antimalarials must be taken for one week before entering a malarial area and for four weeks after leaving – the exceptions are Malarone and doxycycline, which only need to be taken for one to two days before and Malarone only needs to be taken for seven days after leaving. Mefloquine (Larium) only needs to be taken for one week before entering a malarial area, but before taking for the first time, a traveller should take three test doses starting at least five weeks before leaving home, to check for any adverse effects, such as anxiety, depression or panic attacks, which are much easier to identify in a familiar environment. If there are no problems, then the drug can be used for the planned trip and subsequent travel. If there are problems, there is still time to change to another anti-malarial before departure. Although the side effects of mefloquine (Larium) have received the most publicity, it is important to note that ALL anti-malarial drugs have side effects.

D – Report any feverish illness promptly to a doctor and say you have been in a malarious area
It is important to remember that there is no 100% effective method of avoiding malaria. If you experience any flu-like symptoms or any illness while in a malarial area, and within one year of returning, but especially within three months, you should go immediately to a doctor and mention possible exposure to malaria, even if they don't ask you.

Information about vaccinations and malaria prophylaxis

The best single website to for UK residents to check vaccinations and malaria prophylaxis for individual countries is www.fitfortravel.nhs.uk. This website is maintained by the NHS in Scotland.

Diseases for which there are no vaccinations nor prophylaxis

The bad news is that there are not vaccinations nor prophylactic tablets to prevent many infections. The good news is that some simple precautions do lessen the chances of getting many.

Diseases from contact with fresh or brackish water

The two main infectious diseases that can be caught from contact with freshwater are leptospirosis or Weil's disease and bilharzia or schistosomiasis.

Leptospirosis or Weil's Disease
This disease is infamous following the outbreak during the Eco Challenge in Malaysia in 2000, which resulted in many cases – up to half of 312 participants may have been affected. In fact, it is present all over the world, but the bacteria survive and thrive best in warm moist environments. Waterproof plasters to cover wounds may help to reduce the chance of infection – provided they stay on. The incubation period (between infection and symptoms) is 7 to 12 days. As with many "exotic" infections, the key action is to find a doctor soon and emphasis what you have been doing and where. Treatment with antibiotics may aid recovery if given within 72 hours of first symptoms. Antibiotics can be given prophylactically to those at risk through their occupations eg sewerage workers. The Leptospira Reference Laboratory at Hereford Public Health Laboratory can offer information and advice to health professionals. For general information, see the Health Protection Agency webpage
http://www.hpa.org.uk/infections/topics_az/zoonoses/leptospirosis/gen_info.htm

Schistosomiasis or Bilharzia
This is most common in slow moving rivers or still water bodies, such as lakes. It is present in some Caribbean islands, north east coastal South America, much of sub Saharan Africa (Lake Malawi is the best known location for infections), parts of Arabian peninsula and parts of south east Asia. A few hours after contact with infected water, people may experience a tingling or rash, so called "swimmers' itch" and a week later, a high fever. Careful choice of places for contact with freshwater may lessen the chances of infection. Rinsing skin with water not from the same source and rubbing the skin with a rough towel may also lessen the chances, but these actions may not be practical during a race. As before, the key action is to find a doctor soon and emphasis what you have been doing and where. A course of two or three praziquantel (Cysticide®) tablets on a single day will treat early infections. It is only available on a named patient basis, which may require referral to a tropical diseases hospital.

Locally purchased food in Indonesia

Avoiding insect and tick bites

Insects and ticks carry many diseases, many of which do not have vaccinations, preventative tablets or specific treatment. These include Lyme disease and dengue fever. Even if they don't carry disease, they can cause infected bites, which can be very painful or irritating, preventing sleep, for example. The basic approach to preventing bites is to cover skin with adequate clothing (if practical) and use insect repellent on exposed skin or on thin clothing. DEET (diethyl-m-toluamide) is the most reliable chemical for adult skin application, although it can attack plastics and artificial fibres. It is available in many presentations, including sprays and roll-ons, at strengths from 30 to 100%. DEET needs to be reapplied every few hours, more frequently if sweating heavily or after immersion in water. Permethrin can be used to soak clothing and mosquito nets and lasts for several months or washes. Permethrin applied to clothing is not sweated off, as DEET applied to skin can be.

Food and water hygiene: Selecting safer foods

During a race, most competitors rely on packaged foods known from home. Before and after the race, trying local foods is one of the pleasures of travelling overseas. The safest types of foods are those that have been cooked recently and not kept warm (breeding grounds for bacteria) and / or uncovered (exposed to flies) for long periods. So, road side stalls and small cafes, with rapid turnovers, can be safer than western style hotel buffets. The presence of lots of local customers is often an indication of safe food.

Anything that has been made with or washed with suspect water (eg fruit drinks, ice, salads etc), is uncooked and anything made from unpasteurised milk, including ice cream, cheese etc should be treated with caution. Water melons, sold by weight, may have had unclean water added to increase their weight and value. Bananas, protected by tamper evident peels, are among the safest of fruits, as well as being popular with adventure racers.

To summarise: "Peel it, cook it or forget it"

Food and water hygiene: Safer water (for drinking)

If you are not sure of the safety of a water source, whether a bottle, tap or watercourse, then it should be treated, filtered to remove visible contamination, then either treated chemically with iodine, or boiled. Chlorine tablets do not kill as wide a range of diarrhoea causing organisms as iodine. Anyone with thyroid problems needs to seek specific medical advice before using iodine for water treatment. Water bottles may be refilled with suspect water, so the safest options are carbonated drinks, where the "fizz" on opening a bottle shows it has not been tampered with. For other bottles, check the seal carefully for signs of tampering.

Travellers' diarrhoea: Prophylaxis (prevention)

Although not recommended for routine use, daily low doses of broad spectrum antibiotics such as ciprofloxacin 250mg; doxycycline 100 mg; trimethoprim 100mg, can be used to lessen the chance of diarrhoea preventing participation in important events such as races or business meetings. GPs can charge for writing private prescriptions for these antibiotics.

Travellers' diarrhoea: Treatment / Management

The key aim is to prevent dehydration. Electrolyte drinks, containing both sugar and salts in the correct ratios and made to the correct strength, are the most effective. Dioralyte®, Electrolade® and Rapolyte® are the main UK trade names of oral rehydration salts, plus chemists' and supermarkets' own brands. The drugs most commonly used in the UK for stopping diarrhoea are loperamide (Imodium®) and diphenoxylate plus atropine (Lomotil®). Imodium® / loperamide, Pepto Bismol (contains bismuth subsalicylate) and Diocalm (contains morphine and attapulgite) can be bought over the counter in the UK. As is so often the case, generic or own brands are cheaper than branded medicines. These should only be used when essential eg during races, long journeys, business meetings etc.

High altitude

The best way to cope with high altitude is taking time to acclimatise to the lower levels of oxygen in the air – actually, the proportion doesn't change, but there is less density of air, and so less or each component gas, including oxygen. A diuretic drug, Diamox ® / acetazolamide, is used to assist with acclimatisation. However, its use is banned in some competitions. For information about use of drugs in sports, consult the UK Sport Drug Information Database (DID) or UK Sport Drug Information Line 020 7841 9530 (+44 20 7841 9530 from outside UK).

If anyone suffers the signs and symptoms of High Altitude Pulmonary Oedema (HAPE) or High Altitude Cerebral Oedema (HACE), the first aid treatment is immediate descent, accompanied by someone else. Early signs and symptoms are headache, nausea, anorexia (loss of appetite) and insomnia. Later, danger signs and symptoms are: vertigo, vomiting, apathy, staggering and difficulty in breathing. (By the way, a symptom is something that the person suffering notices, while a sign is something that has to be looked for, usually by someone else)

Sun protection

Adventure racers are probably most likely to become sunburned when they forget to apply sunscreen after a night session or on overcast days, when the sun does not appear as strong as it really is. Small containers of sunscreen are useful – plastic 35mm film containers are ideal.

Flying and deep vein thrombosis (DVT)

Immobility for long periods, such as sitting in a plane, car, bus or train, is a risk factor for blood clots in the legs (called deep vein thrombosis), which may move to the lungs (called pulmonary embolus). Flights longer than four hours may be associated with an increased risk – World Health Organisation studies suggest there is 1 case of DVT in 6000 journeys over four hours. However, some people are at greater risk than others:

- tall people – over 6ft / 1.83m
- over 40 years of age
- who have already had blood clots
- with a family history of blood clots
- suffering from cancer
- previously treated for cancer
- with certain blood diseases
- being treated for heart failure and circulation problems
- previous stroke

- recent surgery especially on hips or knees (within last three months)
- with an inherited clotting tendency
- women who are pregnant
- women who have recently had a baby
- women are taking the oral contraceptive Pill
- women who are taking hormone replacement therapy (HRT).

If any of the above apply to you, then consult your doctor (or family planning clinic or midwife where appropriate) before travelling. They may recommend taking new or increased doses of medication and / or wearing specially fitted compression stockings.

Anyone can help to reduce their risks by:

- getting comfortable and reclining as much as possible
- bending and straightening legs and feet very half hour of so
- pressing the balls of your feet hard into the floor or footrest to increase blood flow in your legs
- doing upper body and breathing exercises
- taking occasional walks around the cabin
- taking advantage of refuelling stops, where it may be possible to get off the plane
- drinking plenty of non-alcoholic drinks
- avoiding alcohol – excess leads to dehydration and immobility
- avoiding taking sleeping pills, which reduce movement.

For further information see the Department of Health webpage Advice on travel-related DVT

Racoon in Costa Rica

Insurance and documentation for adventure racing outside the UK

Travel insurance:
Appropriate insurance to cover medical expenses in the case of illness or injury is vital. Many regular policies, including some offered free by banks, for example, exclude competitive events, so check any policy before relying on it. Snowcard.co.uk offer policies at 6 levels of activity (level 5 for amateur competition) for either medical and rescue expenses only or medical, rescue and personal effects or medical, rescue and cancellation or comprehensive medical, rescue, personal effects and cancellation.

European Health Insurance Card (EHIC):
The previously used E111 is no longer valid. The new European Health Insurance Card entitles UK residents to reduced cost medical treatment in the following countries of the European Economic Area, plus Switzerland: Austria, Belgium, Cyprus (but not Northern Cyprus), Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain and Sweden.

- See this Department of Health webpage for details and link to application process.

Blood transfusions:
Standards for screening blood in some countries do not match those for screening blood from volunteer donors in the UK. As an alternative, the not-for-profit Blood Care Foundation offers membership to travellers overseas.

- Blood Care Foundation website

First aid / Medical kits

In addition to the minimum first aid kits required by race organisers, and normal first aid supplies, competitors may want to consider carrying extra items:

- Needles for intradermal intramuscular and intravenous injections
- Needles and sutures for closing wounds
- Infusion set for administering intravenous fluids
- Steristrips ® / Leukostrip ® and / or glue to close wounds without needles and sutures
- Iodine solution for treating suspect water and also cleaning wounds
- Soluble vitamin C tablets to improve taste of iodine treated water
- Insect repellent sprays / lotions etc, containing DEET
- Sunscreen
- Lip salve and / or petroleum jelly
- Adequate quantities, plus spares, of essential personal drugs
- Diarrhoea treatment – oral rehydration sachets plus tablets to "bung"
- Thermometer which does not contain mercury
- Extra kit as required by those with long term medical conditions eg medication, injection devices, inhalers, latex gloves etc.

Pre-existing Medical Conditions
Most people who live with long term medical conditions, such as asthma, diabetes, epilepsy, HIV etc and compete in adventure racing are pretty good at managing their conditions. Medical advisors may be very unfamiliar with adventure racing and need some explanation before being able to help. In some cases, people living with conditions may be good sources of advice eg http://diabetic.friendsinhighplaces.org/ includes reports from races, expeditions and climbs all over the world.

Drug storage box with soon to be evicted snake, Mexico

International first aid, medical and drug terms:

Sources of information about health overseas for adventure racers

Websites:

- The best single website to for UK residents to check vaccinations and malaria prophylaxis for overseas travel is www.fitfortravel.nhs.uk. This website is maintained by the NHS in Scotland.
- For more general information about health, try www.dh.gov.uk (Department of Health) and for general information about infections in particular, try www.hpa.org.uk

Books:

For more information than you probably need, there are two books I have found particularly useful:

- Richard Dawood (editor), *Travellers' Health: How to Stay Healthy Abroad*, Oxford University Press, 4th edition, 2002, ISBN 0192629476. Contains chapters written by specialists on a range of conditions, activities etc.
- Jane Wilson Howarth, *Bugs, Bites & Bowels*, Cadogan Guides, 4th edition, May 2006, ISBN 186011332. Written by a biologist turned doctor, so it's full of biological detail, plus anecdotes from adventurous travellers.

Articles:

If you encounter a practice nurse puzzled by adventure racing, you might like to suggest they look at my article, Travel Health Clinic: Adventure racing, in Practice Nursing, March 2006, Vol 17, no3, pages 130 – 133.

Summary

- Don't let concerns about health prevent you competing overseas.
- When they are available, use vaccinations and prophylaxis to protect yourself.
- Seek advice early from your GP's surgery.
- Use independent UK based advice sources – local tourist boards do not want to advertise health risks and countries vary in their advice to their citizens about precautions.
- Take realistic precautions against ingesting contaminated food and water, contact with freshwater and insect bites.
- If you fall ill after returning from overseas, consult a doctor and emphasise where and what you have been doing. Of course, it might be a cold, but better to be sure.

This article will be updated as necessary

About the author:

Jean Sinclair is Research Assistant / Research Nurse at the Department of Haematology, University of Cambridge. She has published several journal articles and has contributed a chapter on expedition health in Richard Dawood's *Travellers' Health* (OUP, 4th edition, 2002). Jean is a keen traveller and AR fan, and has marshalled at many events.

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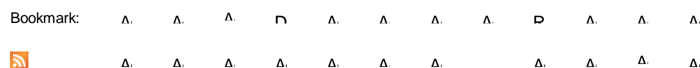

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