Travellers' diarrhea – Curry and a hurry?

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PA: What is the magnitude of the problem of travellers' diarrhea (TD)?

DC: TD is very common. A study on people travelling to Latin America showed a 70% incidence of TD for a two-week trip (1). Some destinations are lower risk, but the worst case I have ever encountered was acquired in a little-known, and exotic, place called San Diego, California (USA). Probably over 80% of travellers avoid seeking pretravel advice because of ignorance or because they are afraid to get treatment through needle injection. Needle phobia is very common.

PA: Can you outline an approach to prevent TD?

DC: The standard 'boil it, peel it, cook it or forget it' is theoretically fine, but the lack of compliance is almost universal. People get back home and say, 'I know what got me in trouble. It was that salad on Saturday night.' I counsel them on safe eating (and safe sex!) anyway, but I often use the oral TD or cholera vaccine (Dukoral [sanofi pasteur, Canada]). My frequent travellers swear by it. I never prescribe prophylactic antibiotics.

PA: When a person is on vacation and starts having diarrhea, what are the next steps?

DC: For attacks of diarrhea on vacation I used to recommend a three-day course of a fluoroquinolone, but because antibiotics are contraindicated in cases of salmonellosis and vero cytotoxin-producing *Escherichia coli* infection, I seldom prescribe them anymore. My first choice therapy is oral rehydration and bismuth subsalicylate tablets (Pepto-Bismol [Procter & Gamble Inc, Canada]). This has the advantages of safety, and settling both upper and lower gastrointestinal upsets. Most physicians (and the package instructions) recommend a subtherapeutic dose. I recommend chewing two tablets every 30 min for a total of eight doses. Loperamide is a very popular over-the-counter

remedy but unless the diarrhea is well established as watery (no blood and no mucus) and the patient is otherwise well (no cramps and no fever), I do not recommend it.

PA: This seems to be an area where the doctor advises the patients differently than they treat themselves and their family.

DC: Physicians have a low threshold of prescribing antibiotics for themselves or their families, but I do not. At least physicians have (or should have) some idea of the risks. Antibiotic resistance is so bad in some areas, particularly Thailand, that this approach is almost worthless anyway.

PA: When a patient returns from vacation to your clinic with diarrhea, would you recommend stool analysis or treatment?

DC: Most people clear up within one week or two. If they are symptomatic longer than that, have severe symptoms, or are employed as a food handler or health care worker, stool culture and ova and parasite examinations are warranted.

PA: Do you see a role for sigmoidoscopy or colonoscopy in the traveller patient with bloody diarrhea?

DC: Absolutely. If a patient has severe or bloody diarrhea, and negative stools (particularly if there are lots of pus cells), they usually have inflammatory bowel disease. It has to

start sometime and it could be on vacation. The sooner they are properly diagnosed the better.

PA: Some experts suggest different approaches based on the importance of or duration of time in the endemic country? Do you tailor your approach to the individual situation?

DC: I tailor my approach to the degree of risk, not the duration of the trip. Many people take short holidays now. The impact of an attack of TD on a one-week trip is much worse than on a three-month trip. One meal is all it takes to cause an illness, which can be severe or protracted.

REFERENCE

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