Yellow fever – prevention in travellers

Dear Editor

We compliment Nielson and Mayer (*AFP* August 2010) on their succinct account of yellow fever prevention in travellers. Any apprehension among travellers to yellow fever endemic areas could be softened through prior briefing about the basics of the biting habits of the two vectors.

Aedes aegypti is an early morning or late afternoon biter, but will also bite at night under sufficient artificial lighting. The *A. aegypti* is particularly fond of human ankles when it is searching for a good spot to light and bite a human! *A. albopictus* has also been reported as an efficient vector of yellow fever virus.[1]
A. albopictus is an aggressive day time biter with peaks generally occurring during the early morning and late afternoon. It is a container inhabiting species which lays its eggs in any water containing receptacle in urban, suburban, rural and forested areas.[2]

Conventionally, antimosquito measures are practised only during the night hours, with travellers tending to use repellents, insecticides or mosquito nets. Nevertheless, after such a meticulous nocturnal approach, travellers inadvertently expose themselves to bites from infected vectors of yellow fever, especially on the lower extremities.

Travellers on business dress formally while on official engagements, however, during their leisure time, like others on a holiday, they dress informally and are exposed to vector bites. For protection against yellow fever, it is better to avoid wearing shorts and short skirts. A recommendation to wear trousers or slacks would be applicable to both genders. Socks should be worn while moving outdoors during the day time. Last but not least, every traveller must invariably apply repellents and insecticide creams while on excursions in urban, suburban, rural or forested areas.

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References

1. Miller BR, Mitchell CJ, Ballinger ME. Replication, tissue tropisms and transmission of yellow fever virus in Aedes albopictus. Trans R Soc Trop Med Hyg 1989;83:252–5.
2. Novak R. The Asian tiger mosquito, Aedes albopictus. Wing Beats 1992;3:5.

Quality use of medicines in residential aged care

Dear Editor

I would like to thank Somers et al[1] for their article (*AFP* June 2010) as it raises a whole range of issues. However, they may not be the issues they initially considered.

Why was there no general practitioner in their research group and why was ethics approval not sought from a GP ethics committee? After all, this article will reflect strongly on GP practice in aged care. Did the consensus group that established the Beers criteria include GPs? I ask because the list includes medications that are often used by peers that I respect.

As a GP and a researcher, I am only too aware of the political and legal implications of what I write and how I write it. I also rely on GP ethics committees to scrutinise my submissions when what I write affects GPs. If I were a young doctor reading this article, I would think that aged care was too hard and that its current medical workforce was incompetent. As an experienced GP, I know both these statements to be incorrect.

The heading 'potentially inappropriate medications' is itself incomplete and misleading. What it really refers to is that the listed medications should be used with care and only after careful consideration. General practice is not an exact science but a compromise between the best evidence and the best possible.

The difficulties of GP participation in aged care are legion. Indeed the first two pages list very common challenges faced by every doctor in aged care. Many of the issues raised are not pharmacological but logistical.

Workforce. Are there sufficient permanent (not locum or agency) GPs, nursing staff, allied health and support staff who are able to consistently communicate and cooperate as a team?

What is the level of communication and cooperation between GPs, the facilities and supplying pharmacies? This also applies to consulting pharmacists who do medication reviews. Are the facilities appropriately designed and resourced to provide appropriate nonpharmacological interventions?

In short, while raising multiple challenges in aged care, this paper does nothing to explain or explore the reasons behind these difficulties, it has the potential to create scandal and malign GPs who are doing a very difficult job in less than ideal circumstances and offers no avenues for improvement.

Chris Hogan
Sunbury, Vic

Reference

1. Somers M, Rose E, Simmonds D, et al. Quality use of medicines in residential aged care. Aust Fam Physician 2010;39:413–6.

Reply

Dear Editor

We thank Dr Hogan for his letter. We agree that our study was descriptive and does not allow for conclusions to be drawn regarding the appropriateness of prescribing. Dr Hogan has highlighted the complexity and challenges of medical care for residential aged care facilities residents. We share these concerns,[1] and endorse efforts to achieve multidisciplinary solutions that facilitate improved care by GPs, nurses, allied health and care staff for the benefit of residents.

Michael Somers, Ella Rose, Dasha Simmonds, Claire Whitelaw, Janine Calver and Christopher Beer
Perth, WA

Reference

1. Beer C, Horner B, Almeida OP, et al. Current experiences and educational preferences of general practitioners and staff caring for people with dementia living in residential facilities. BMC Geriatr 2009;9:36.

Rabies – prevention in travellers

Dear Editor

The article by Neilson and Mayer (*AFP* September 2010) provides a review of rabies prevention in travellers, however, there are some important points which we would like to bring to the attention of your readers.

- Bali has been recognised since December 2008 as having endemic rabies. The paper by Neilson and Meyer misses an opportunity to promote awareness of this. An alert to medical practitioners advised that anyone who presents in Australia with a history of bites or scratches from any animal in Bali at any time since 1 August 2008 requires risk assessment for rabies. Since then there have been reports of up to 93 human cases of rabies acquired in Bali.[1] Public health units regularly provide postexposure prophylaxis to people who have returned from Bali following a potential exposure to rabies. More awareness of this risk among travellers to Bali, pre-exposure vaccination and avoidance of potential exposures would reduce this requirement
- *Table 2* presents the World Health Organization (WHO) view of rabies postexposure management. In Australia, all potential exposures (including scratches) warrant consideration of the use of rabies immune globulin (RIG). Although RIG is in short supply, each exposure is considered on its merits for full postexposure treatment
- Depending on the jurisdiction, access to RIG and expensive postexposure treatment is generally coordinated through public health units.

The WHO has recently published a position paper on rabies vaccines, citing the work of the United States Centers for Disease Control and Prevention which considers the use of a four dose rabies vaccine postexposure schedule when given with adequate wound care and high quality RIG.[2,3] While this has not yet been endorsed in Australia, it represents an important international development in rabies control.

Brad McCall, Rod Davison
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2. WHO Position Paper. Rabies vaccines. Weekly Epidemiological Record. Available at www.who.int/wer/2010/wer8532/en/index.html [Accessed 14 Sept 2010].
3. Rupprecht CE, Briggs D, Brown CM, et al. Evidence for a 4-dose vaccine schedule for human rabies postexposure prophylaxis in previously nonvaccinated individuals. Vaccine 2009;27:7141–8.

Reply

Dear Editor

We thank Doctors McCall and Davison for their comments regarding our review article on rabies prevention in travellers. In particular, thank you for drawing attention to the recent rabies outbreak in Bali. This should have been mentioned in the article.

It is also helpful to note your comments regarding postexposure management and the role of public health units in this.

Cora A Mayer
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Amy A Neilson
Brisbane, Qld

Oral hypoglycaemics

Dear Editor

The article 'Oral hypoglycaemics – a review of the evidence' (*AFP* September 2010), provides an overview of the range of oral hypoglycaemic agents currently available in Australia, including the gliptins (sitagliptin or vildagliptin). The gliptins exert their hypoglycaemic effect via inhibition of dipeptidylpeptidase 4 (DPP4) activity, reducing the breakdown, and potentiating the action of 'incretins'. This pharmacological effect may create the potential for interactions with other drugs.

Other peptides, such as substance P and bradykinin, are also substrates for DPP4, and may be potentiated with the use of DPP4 inhibitors. These peptides have effects on vascular permeability and are thought to play an important role in the pathogenesis of angiotensin converting enzyme (ACE) inhibitor associated angioedema. A recent study has shown that among individuals taking an ACE inhibitor, vildagliptin use was associated with an increased risk of angioedema, odds ratio 4:57 (95% confidence interval 1.57–13.28).[1]

Vildagliptin, and potentially sitagliptin use may be associated with increased risk of angioedema among patients taking ACE inhibitors. Given the widespread and long term use of ACE inhibitors, and the potential for long term use of the gliptins, it is important that prescribers are aware of the potential for this interaction.

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Reference

1. Brown NJ, Byiers S, Carr D, et al. Dipeptidyl peptidase-IV inhibitor use associated with increased risk of ACE inhibitor-associated angioedema. Hypertension 2009;54:516–23.

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