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Issue: Public health intervention for refugees

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Editorial

The refugee crisis due to war conflicts in the Middle East and African Horn generated about 1.5 million refugees per year. About 1.2 million arrived in 2015-2016 from Syria, Lebanon, Iraq and Afghanistan through the Balkan route via Greece to Austria and Germany and about 0.3 million via Italy (Sicily, Lampedusa) and Malta through a Mediterranean Route containing migrants from North and Sub-Saharan Africa (1-3). This heavy coin is handled by the European Union with caution as the first side of the coin (the Turkish/Greece Route) does not represent any major health care problems (not one outbreak of infectious diseases was observed in the “Balkan route” in 2015/2016); the second side of the coin representing refugees/migrants from Africa to Europe carries several infectious and/or tropical diseases from Sub-Saharan Africa and SE Asia with classic triage for tuberculosis, AIDS and malaria, followed by Hepatitis B and C and soil transmitted helminths.(4-7). This monothematic issue, with analysis of epidemiology from both sides of the coin including the proposal for migrant screening of risk factors for tropical diseases (not only) in migrants but also internally displaced and genocide victims.

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Few words from the Editors-In-Chief

This journal brings authentic experiences of our social workers, doctors and teachers working for the International Scientific Group of Applied Preventive Medicine I-GAP Vienna in Austria, where we have been preparing students for the social practise over a number of years. Our goal is to create an appropriate studying programme for social workers, a programme which would help them to fully develop their knowledge, skills and qualification. The quality level in social work studying programme is increasing along with the growing demand for social workers.

Students want to grasp both: theoretical knowledge and also the practical models used in social work. And it is our obligation to present and help students understand the theory of social work as well as showing them how to use these theoretical findings in evaluating the current social situation, setting the right goals and planning their projects.

This is a multidimensional process including integration on many levels. Students must respect client's individuality, value the social work and ethics. They must be attentive to their client's problems and do their best in applying their theoretical knowledge into practice.

It is a challenge to deliver all this to our students. That is also why we have decided to start publishing our journal. We prefer to use the term 'clinical social work' rather than social work even though the second term mentioned is more common. There is some tension in the profession of a social worker coming from the incongruity about the aim of the actual social work practice. The question is whether its mission is a global change of society or an individual change within families. What we can agree on, is that our commitment is to help people reducing and solving the problems which result from their unfortunate social conditions. We believe that it is not only our professional but also ethical responsibility to provide therapeutic help to individual and families whose lives have been marked with serious social difficulties.

Finding answers and solutions to these problems should be a part of a free and independent discussion forum within this journal. We would like to encourage you – social workers, students, teachers and all who are interested, to express your opinions and ideas by publishing in our journal. Also, there is an individual category for students' projects.

In the past few years there have been a lot of talks about the language suitable for use in the field of the social work. According to Freud, a client may be understood as a patient and a therapist is to be seen as a doctor. Terminology used to describe the relationship between the two also depends on theoretical approach. Different theories use different vocabulary as you can see also on the pages of our journal.

Specialization of clinical social work programmes provides a wide range of education. We are determined to pass our knowledge to the students and train their skills so they can one day become professionals in the field of social work. Lately, we have been witnessing some crisis in the development of theories and methods used in clinical social work. All the contributions in this journal are expressing efforts to improve the current state. This issue of CWS Journal brings articles about social work, psychology and other social sciences.

Michael Olah
Peter G. Fedor-Freybergh
Edition of the journal

Longitudinal survey of ATB resistance reversibility in children with AIDS of genocide survivors in Cambodia

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Key words:

HIV, AIDS, antimicrobial resistance.

Key message:

ATB, resistance in HIV positive children is reversible.

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Abstract:

Background: The aim of the survey was to assess antimicrobial resistance dynamics and reversibility in the group of children with AIDS in Cambodia in 2003 - 2015.

Patients: Correlation between antimicrobial (ATB) resistances in commonest respiratory isolates among 140 children with AIDS on antiretroviral therapy was studied from 2003 to 2015 in 586 isolates.

Results: All but 3 (98%) children showed a sustained CD4 increase after introduction of antiretroviral therapy (ART) followed by a decrease of ATB resistance. In our group of children restoration of the immune system decreased the number of infection diseases episodes and the proportion of multi-resistant bacterial strains.

Conclusions: Less frequent use of antimicrobial therapy probably led to the decrease of multi-resistance and restoration of susceptibility of studied respiratory bacterial isolates.

Introduction

Reversibility of ATB resistance has been described on both countrywide and hospital level (1-3), however specific patient groups have been rarely addressed in adults with HIV or Ebola in Sub-Saharan Africa (4-5). Antibiotic resistance is of great concern in patients with AIDS, who are frequently treated with antivirals, antibiotics and anti-tubercotics for various opportunistic infections. After the introduction of highly active antiretroviral therapy in 1990/2000 most opportunistic infections (OI) decreased. Therefore, also the amount of prophylactically and therapeutically administered antibiotics decreased. Because the amount of antibiotic agents is one of the drivers of ATB resistance, also resistance to antibiotics and anti-tubercotics should decrease. The aim of this longitudinal research is to determine if resistance of commonest respiratory agents have decreased after the implementation of ART in children in community settings.

Patients and methods

This longitudinal study includes 12 years (2003-2015) follow up of susceptibility to antibiotics of upper respiratory tract isolates from nose and pharyngeal swabs in children 4-12 years on HAART. 98% of children showed CD4 increase within 6 months on ART to normal level $> 25\%$ or $> 350/\text{mm}^3$). In the statistical analysis, t-test for trends was used to compare ATB resistance in 2003 to 2015 (EPI INFO version 2014).

Results and discussion

Table 1 presents trends in ATB resistance in major respiratory isolates from October 2003 to December 2015 (total of 586 isolates). Penicillin resistance in pneumococci decreased from 25% to 2% in 2015 ($P < 0.01$); t-test for trends), MRSA from 33.3% in 2003 to 3% in 2014 and 2% in 2015 ($P < 0.01$). Erythromycin resistance in *Streptococcus pyogenes* decreased from 10.5% in 2003 to 3.3% in 2015. At baseline extremely high proportion of ESBL - producing Enterobacteriaceae decreased from 66.6% to 25% and such trend was also observed in *Candida* species and resistance to fluconazole (from 15% in 2003 to 6% in 2015).

Reversibility of ATB resistance was documented on the hospital level (2) or on the community national level (1,3), however only in countries with small population (Finland, Denmark, Iceland) with centralized ATB policy. Reversibility time was 2-5 years per country and more (up to 5 years). Reversibility of susceptibility or antibiotic resistance was not yet sufficiently studied in pediatric population with specific immunodeficiency therefore it is deficient to assess, of 10 - 15 years in our group is comparable to e.g. 2 - 5 years on a nation level from Europe (5-8).

Conclusions

A decrease of the MRSA, PRP, and ESBL producing Enterobacteriaceae and FLU-R in *Candida* species is in correlation with improved immune status of children with AIDS. Restoration of the immune system with ART led to the CD4 increase and

was logically followed with less HIV related infections (4). Less antimicrobial agents use is possibly responsible for the phenomenon of the reversibility of antimicrobial resistance also in pathogens colonizing in the respiratory tracts of children with HIV on active antiretroviral therapy.

H, LAGER K, HUOVINEN P.: *The effect of changes in the consumption of macrolide antibiotics on erythromycin resistance in group A streptococci in Finland. Finish Study Group for Antimicrobial Resistance.* In NEJ Med. 1997. Aug 14; 337 (7): 441-446

Tab. 1 Antimicrobial resistance pathogens among bacteria colonizing the respiratory tract in Cambodian children with HIV.

N=586	2003	2004	2005	2006	2007	2009	2010	2011	2012	2013	2014	2015
St. pneumoniae	25	15	25,7	21,5	35,5	15,8	4,3	2,2	2,4	2,0	8	2,0
MRSA	33,3	18,5	25,7	23,1	35,5	56,6	19,1	45,1	18	20,0	3,0	2,0
Mocca	12	12,3	7,3	7,7	4	5,3	3,2	4,4	3,3	5,0	3,3	3,3
HAIN	8	4,6	5,8	12,	0,8	0	1,1	1,1	2,5	6,0	4,1	3,3
ERY-R St. pyogenes	10	10,5	15,3	10	12,4	10,5	8,2	5,5	4,5	4,0	5,0	3,3
ESBL ⁺ Enterobacteriaceae	66,6	42,5	72,5	55,5	29,3	35,5	22,2	25	24	30	33	25
FLU-R Candida	15	15	22,5	10,2	5	8,25	5,0	6,0	10	6	5	5
CD4 (mean)	55	121	182	201	198	355	320	406	350	370	401	395

References

- ARASON VA, KRISTINSSON KG, SIGURDSSON JA, STEFANSDOTTIR G, MOLSTAD S, GUDMUNDSSON S.: *Do antimicrobials increase the carriage rate of penicillin resistant pneumococci in children? Cross sectional prevalence study.* In BMJ. 1996, August 17, 313 (7054): 387-391
- BIENERTOVÁ, J., RÜCKER, P. 2015: Sociální rehabilitace - Inkluze osob s disabilitou – iluze nebo realita? In: Rehabilitácia ISSN 0375-0922, Vol. 52, 2015, No 1, p. 57-64
- MUSILOVÁ, E., SUROVČÍKOVÁ, Z. 2015: Sebestačnost po pertrochanterickej fraktúre u seniorov. In: Rehabilitácia. ISSN 0375-0922, Vol. 52, 2015, No 1, p. 12 - 18
- HUOVINEN P, MENNTYJARVI R, TOIVANEN P.: *Trimethoprim resistance in hospitals.* In BMJ (Clinical Res Ed). 1982 Mar 13; 284 (6318): 782-784
- SEPPALA H, KLAUKKA T, VUOPIO-VARKILA J, MUOTIALA A, HELENIOUS
- KRCMERY V, KALAVSKY E. 2007. *Antibiotic and antifungal resistance in antibiotic „free“ environment? Review,* In Neuroendocrinology Letters. 2007 Nov; 28, Suppl 3:33-4
- SUN YS, ZHAO XY, ZHANG BK, JIANG JF, LU HJ, CAO YX, WU GZ, QIAN J, SUN YS, ZENG YJ: Practices and thinking of laboratory detection in the aid to West Africa to fight against Ebola. Bratislava Medical Journal Vol.117, No.5, p.254-257, 2016. doi:10.4149/BLL_2016_049.
- PUTEKOVA S, KABATOVA O, MARTINKOVA J: *Nursing problems in refugees.* In Clinical Social Work, 2015, Vol. 2, p. 33-34.
- WICZMANDYOVA D., MURGOVA A.: *The life of diabetics, life with diabetes.,* Book. Clear Michalovce ISBN 978-80-9711629255 .2012, pp. 67
- SILHAROVA B, SUVADA J, FRANEKOVA M, NOGE A, MIKOLASOVA G: *Malaria in hyperendemic region,* Neuroendocrinology Letters. 34, 2013, s1 38-43

Are migrants from Middle East carriers of multi-resistant bacteria?

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Key words:

Migrants, Refugees, ATB resistant.

Key message:

Refugees and Migrants arriving from Middle East do not represent a significant reservoir of multi-resistant bacteria.

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Abstract:

Background: In 2015 about 1.2 million migrants via the Balkan Route (Greece to Austria and Germany) and about 250,000 migrants via the Sicily (Lampedusa) Malta Route entered the EU.

Patients: Among 544,310 migrants in our field hospitals and checkpoints (Austria, Slovenia, and Greece) from Sept. 2015 to June 2016,

bacterial isolates from patients with respiratory symptoms were obtained and 209 isolates were tested with available antibiotics.

Results: Only 4 Methicillin Resistant *Staphylococcus aureus* MRSA (4%) and 1 Penicillin Resistant *Pneumococcus* PRP we isolated from migrants with symptomatic respiratory infections.

Conclusions: Our small research compared to our expectations did not find any major resistance patterns colonizing or infecting migrants coming to the EU via the Balkan route from Syria, Iraq via Greece to Austria and Germany.

Introduction

Discovery of the NDM-1 “travel” from India to Sweden, or MCR-1 genes coding colistin resistance from China to Europe are examples how multi-resistant bacteria from the 3rd World may enter EU countries, even with strict ATB policy specially via conflict areas or migration (1.2). Middle East and Southeast Asia are leading areas of the last large refugee event (Balkan and Mediterranean Route) whereas 1.35-1.5 million migrants and or refugees crossed the Greek or Italian Mediterranean border in 2015 (3-4). The aim of this short communication is to assess the risk of transfer or MR bacteria (5) within migrants in 2015/2016 from Middle East/Near East countries to the EU and dissolve the fear that refugees/migrants must be necessary carriers (6) of multi-resistant microbes or deadly diseases (6-9).

Patients and Methods

12 Healthcare Workers (HCW) have been serving at the Nickelsdorf/Hegyeshalom (AT/HU) and Dobova/Rigonce (CRO/SL) on 8 hour shifts, serving for 2 - 16,000 migrants per day. The Health Posts and Field Hospital on Austrian, Hungarian, Slovenia borders were opened since September 6, 2015 to March 2, 2016. In the six month period (9/2015 - 2/2016) about 319,500 migrants and or refugees crossed our Healthcare units, most, 90% of them healthy or not seeking medical care. About 29,500 (5,000 per month, 150 - 200 per day) presented themselves to one of our new facilities requiring healthcare and or therapy.

Results and Discussion

Concerning the spectrum of migrants 68% were from Syria, 21% from Iraq and 11% from other Asian countries. (Afghanistan, Pakistan). **Table 1** shows the commonest diagnoses. The majority had surprisingly little tropical, but “civilization” and “stress related” diseases, such as hypertension, coronary heart disease, neurovascular; diseases include decomposed diabetes, asthma, depression, etc., and camping related disorders (pneumonia, infected wounds, etc.). Only about 10% were infections, similar to those we can see in Central/Eastern EU members states Hungary and Slovakia.

From 528 cases of lower respiratory tract infections (L-RTI), we obtained swabs from the oropharynx and nose and in 101 samples pathogenic yeasts or bacteria (**Tab 1**) we isolated. Antibiotic resistance was minimal and did not show any major threat to the host population. Only 1 penicillin-resistant *Pneumococcus*, 4 methicillin-resistant *Staphylococcus aureus* (MRSA) and 1 multidrug-resistant (MDR) gram-negative bacteria (*Klebsiella* spp., resistant to all antibiotics including colistin (**Table 1**) were isolated.

All *Candida albicans* are susceptible to fluconazole (FLU) but 3 of 7 non-albicans *Candida* spp (*C. tropicalis*, *C. glabrata*, *C. krusei* etc.) were FLU resistant. Surprisingly all *H. influenzae* strains are susceptible to ampicillin and all *S. pyogenes* were susceptible to erythromycin.

Conclusion

In conclusion, despite the increasing number of migrants and or refugees via the „Balkan Route“, in contrast to those who are coming via Italy and Malta, our research found only a small proportion (1-4%) of multi-resistant bacterial isolates from the respiratory tract among our group of predominantly Syrian and Iraqi migrants.

References

1. JAVIER GARAU, DAVE P. NICOLAU, BJÖRN WULLT, MATTEO BASSETTI: *Antibiotic stewardship challenges in the management of community acquired infections* Jour. Glob. Antimicrob Resist 2, Issue 4, 2014 245-253
2. YI-YUN LIU, YANG WANG, TIMOTHY R. WALSH, LING-XIAN YI, RONG ZHANG, JAMES SPENCER, *et al*: *Emergence of plasmid-mediated colistin resistance mechanism MCR-1 in animals and human beings in China: a microbiological and molecular biological study* Lancet Infect Dis. 2016, 16, pp161-68
3. PRESTILEO T, DI LORENZO F, CORRAO S: *Infectious Diseases among African irregular migrants in Italy. Just an individual problem?* Clin. Soc. Work 2015, 5, 45
4. FAVILA ESCOBIO, JOTA ECHEVARRIA, SILVIA RUBAKI, VIRAG VINICZAI: *Health assistance of displaced people along the Balkan route*, Lancet 2015, 386, Dec. 19, 2475
5. KULKOVA N, BABALOVA M, BRNOVA J, KRČMERY V: *Transferable Fluoroquinolone resistance in Enterobacteriaceae and Pseudomonas aeruginosa isolated from hemocultures*, Cent Eur J Public Health 2014, Mar, 22(1): 60-3
6. KRČMERY V, KALAVSKY E: *Antibiotic Resistance in "ATB free" environment*. In Neuroendocrinology Letters, 2007, 28, 83, p. 33-34.
7. WICZMANDYOVA D, TKACOVA L, MURGOVA A: *Proceedings. Slovak Med. Univ.: The Socio Economic Aspect of Migrations* ISBN 978-80-89352-47-0, pp.62-70
8. WICZMANDYOVA D., MURGOVA A., *The clife of diabetics, life with diabetes* Book Clear Michalovce ISBN 978-80-9711629255 .2012, pp. 67
9. SILHAROVA B, SUVADA J, FRANEKOVA M, NOGE A, MIKOLASOVA G: *Malaria in Hyperendemic Region*, Neuroendocrinology Letters. 34, 2013, s1 38-43
10. SUN YS, ZHAO XY, ZHANG BK, JIANG JF, LU HJ, CAO YX, WU GZ, QIAN J, SUN YS, ZENG YJ. *Practices and thinking of laboratory detection in the aid to West Africa to fight against Ebola*. Bratislava Medical Journal Vol.117, No.5, p.254-257, 2016. doi:10.4149/BLL_2016_049.

Tab. 1 Etiology and antimicrobial resistance of respiratory tract isolates in migrants with symptomatic L-RTI travelling on the Balkan Route from Sept 2015 to Feb 2016 (6 months period)**Spectrum of 101 throat/nose isolates**

- *Moraxella catharralis*: 12
- *S. aureus*: 16 (4 MRSA - 25% of all *S. aureus*, and 4% from all isolates)
- Other Streptococci: 8
- *S. pyogenes*: 4
- *H. influenza*: 6
- *S. pneumoniae*: 8 (1 penicillin resist., 12.5%, of *S. pneumonide*, and 1% of all isolates)
- *Enterobacteriaceae*: 16 (Multi-resistant 1 strain, *Klebsiella pneumonia* 6.25% of all ENT, 1% of all isolates)
- *Ps. aeruginosa* : 5
- *Acinetobacter baumannii*: 2
- *Candida albicans*: 14
- Non-candida spp.: 7
- Other: 3

Reversibility of antibiotic resistance on country level – how long does it take? (Letter)

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In a recent paper and similar editorial published in the April 2016 Issue of *The Lancet*, I.M. Gould and Timothy Lawes [2] and on similar issues of *Medical Review A*. Shahum *et al* (6) data or reversibility of ATB resistance are rare. They discussed the reversibility of antibiotic (ATB) resistance on country levels in dynamic scale in 2000 and also in 2014. This dynamic data opens a question - how long does it take that the susceptibility to return to previous levels. There is very little published on reversibility of antibiotic resistance on country levels, in contrast to numerous reports on hospital levels and also in specific patients groups [3]. The question how long does it take to repair the negative consequences of ATB over

prescription was addressed in a few studies from less populated Scandinavian countries, e.g. Finland [4]. Gould's and Lawes's paper is one of the very few longitudinal comparisons of consumption data within recent years, and are available due to the results from the European Study of Antibiotic Consumption (ESAC) [5]. Again, apart from France, all other 5 countries which showed decline of ATB consumption were "small" countries with centralized antibiotic policies (Slovakia, Slovenia, Lithuania, Estonia and Portugal).

According to our experience from the leading Antibiotic Committee of the Ministry of Health of the Slovak Republic, unacceptably high consumption was managed with at least 3 administrative and financial mechanisms:

- deleting of specific ATB classes temporary from National ATB formulary
- increasing of co-payment in reimbursement as a national strategy,
- prescription limits, temporary shifting ATB to Category B (results of susceptibility required) or Category C (written agreement from the Regional or Hospital Antibiotic Committees).

Slovakia which succeeded to control ATB consumption also decreased or stabilized Penicillin resistance in pneumococci and ampicillin resistance in H. influenza, as well as MRSA. It is easier to have restrictive centralized antibiotic policy in small countries and with centralized health policies, than in large countries, affected by the migrant crisis in the last 2 years (UK, France, Italy and Greece). Hallsworth's *et al* [6] study is an example is that a behavioral approach not limited to one hospital (7-10) or department can be successful in ATB prescription control also in large countries.

References

1. KRČMERY V, KALAVSKY E: *Antibiotic Resistance in "ATB free" environment*. In Neuroendocrinology Letter, 2007, 28, 83, p. 33-34.
2. GOULD IM, LAWES T: *Antibiotic stewardship: prescribing social norms* The Lancet Vol. 387, No. 10029, p1699-1701, 23 April 2016
3. KRČMERY V, TRUPL J: *Bacteraemia due to penicillin-resistant Streptococcus viridans in cancer patients, before and after prophylaxis with penicillin* The Lancet 1995 Nov 18; 346(8986):1362-3.
4. SEPPÄLÄ H: *The Effect of Changes in the Consumption of Macrolide Antibiotics on Erythromycin Resistance in Group A Streptococci in Finland*: NE J Med 1997; 337: 441-44
5. GOOSENS H: *Outpatient antibiotic use in Europe and association with resistance: a cross-national database study*. The Lancet 2005 Feb 12-18; 365(9459): 579-87.
6. HALLSWORTH: *Provision of social norm feedback to high prescribers of antibiotics in general practice: a pragmatic national randomized controlled trial*. The Lancet Volume 387, No. 10029, p1743-1752, 23 April 2016
7. SILHAROVA B, SUVADA J, FRANEKOVA M, NOGE A, MIKOLASOVA G: *Malaria in hyperendemic region*, Neuroendocrinology Letters 34, 2013, s1 38-43
8. SUVADA J, CZARNECKI P, TOMANEK P, JANKECHOVA M *et al*. *Social Pathology in Health Care*. WSM. Warszav, 2015, pp. 455.

Screen or not to screen? 7 questions in prevention of infection from refugees and migrants

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Migrants from Africa to EU have to be screened at least for HIV, HBV, HCV and malaria and vaccination history.

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Abstract:

Introduction: The aim of this paper was to review the preventive strategies for screening of commonest infections in migrants. Germany, UK, France, Spain and Italy have highest numbers 25 mil migrants (31% of global migrant population) 70% from EE and North Africa 1.9 million per year illegally, eg. Italy 250,000, Spain 200,000, Turkey 200,000/

year. To protect the EU from TB, HIV, HB, RTI, and possibly malaria and vaccination - preventable ID (RTD) we have to screen at least migrants and refugees. The question is about international travelers or internally displaced due to catastrophe, genocide or civil war, where similarly important as screening is the determination of vaccination status. Methods: Our and others experience on screening of migrants via the Mediterranean route versus Balkan route plus own experience from health posts in Hungary, Slovenia, Austria, Greece, Lebanon, Italy is presented. Results: Proposals for screening of ID are presented for health posts for HIV, HBV, HCV, TB, malaria as baseline for possible guidelines for migrants refugees screening.

Conclusion: Screening of selected ID (TB, HIV, HW, HBV, Malaria) and vaccination status in migrants and refugees to EU from Africa is mandatory.

Introduction: Seven (7) questions in Migrant Health: Who, why, what, when, where, and who will pay?

- Who should be screened? Migrants, refugees, international travelers? Internally displaced? (Tab.1)
- Why are we screening? To prevent the transmission of TB, HIV, HB, HCV etc. to EU
- What do we screen? TB, HIV, Hepatitis B, C (Malaria? Helminths?) (Tab. 2)
- When and how quick do we screen? On site or in quarantine + quick rapid diagnostic tests (Tab.3)
- Where to be screened – compulsory in quarantine. Voluntary in open detection (Tab. 4)
- Who will pay? WHO, EU, grants, UN-HCR (Tab. 5)

Tab. 1

Who should be screened

- 1) International travelers from tropics – no
- 2) Migrants – yes
- 3) Refugees – yes
- 4) Internally displaced – no
- 5) Adoptees – yes

Tab. 2

What to screen:

- TB, Hepatitis, HIV, Malaria, Vaccination status (at least)
- Respiratory diseases in low income migrants, who are afraid of admission to the hospital 50% of migrants in UK have TB, that is why UK has the highest prevalence of TB in EU
- Norway, UK, Switzerland – from 3m they apply for residence
- Easiest screening – anamnesis, PPD (Mantoux), questionnaire, Gene-XPert gene RIF TB
- Vaccinate all for MMR 1x, DTP 1x, Hepatitis B, if vaccination status unknown
- Openness to health services for unsecured migrants: most EU are opened or semi-opened
- Emerging – all, other Greece and Germany offer only partial protection, Poland and Spain – full protect
- Other EU member states– free

Tab. 3

Where do we screen:

- 10 Upon arrival or in quarantines
- Questions for anamnesis in Refugees to screen ID at arrival:

- Fever – Housing Refugees,
- Sweets – 5 liter water per day,
- Weight Loss – Food 1 x day,
- Cough – Housing
- Contacts – Contacts with TB home, school
- Status of vaccination – Basic vaccine (DTP + MMR/1 x)
- Diarrhea – Latrines 1 per 50 – 100
- Hemoptysis – Managing dead bodies

Tab. 4

Where to be screened?

Rapid tests available for screening: upon arrival or in quarantine (1M):

HIV – yes - 2 min.

TB – yes (Mantoux, GeneXpert) - 20 min.

HCV – yes - 20 min.

HBV – yes - 5min.

Malaria – yes - 2 min.

Tab. 5

Who will pay:

Access to healthcare in migrants

- about 20 million people in EU who are not European citizens
- Top 7 – Syria, Iraq, Afghanistan, Eritrea, Libya,
- Multi-cultural
- human risks, viral to bacterial infections
- establish for public health,
- equity in Health care (treat everybody).
- Full access – PT, SP, CU, FR, NL (IT, UK, BG – partial access), Turkey – free access
- No or limited Access – Germany, Greece, East Europe, none.
- EC Council 2003/T/EC from 27.1.2003 (Council Direction): “Asylum seekers must be asked to receive full assistance including Healthcare, including basic food and housing”

Conclusions

Turkish action is an example for Refugees/Migrants Post Emergency – “Turkish” Example (TE): Syrian/Iraqi conflict generated:

- 6 million refugees, 24% war refugees, 11% asylum seekers, 35% migrants, 30% IDPT. Do not ask: Who is a refugee? (Who must cross border because of discrimination etc.). Just look and help (action)
- Turkey took 3 million, Iran 0.5 million, AFAD (Turkish Republic Disaster Emergent Migrant *Directable charte*) – Lebanon 1.5 mil., Germany 1.2 mil., UK 250,000, IT 250,000, other EU 300.

References

1. PRESTILEO T, DI LORENZO F, CORRAO S: Infectious Diseases among African irregular migrants in Italy. Just an individual problem? Clin. Soc. Work 2015, 5, 45
2. KRCMERY, V., KALAVSKY, E.: Antibiotic Resistance in “ATB free” environment. In Neuroendocrinology Letters, 2007, 28, 83, p. 33-34.
3. FAVILA ESCOBIO, JOTA ECHEVARRIA, SILVIA RUBAKI, VIRAG VINICZAI: Health assistance of displaced people along the Balkan route, Lancet 2015, 386, Dec. 19, 2475
4. WICZMANDYOVA, D., TKACOVA, L., MURGOVA, A.: Proceedings Slov. Med. Univ.: The Socio Economic aspect of Migration of Nurses, ISBN 978-80-89352-47-0, pp. 62-70
5. WICZMANDYOVA D, MURGOVA A, The life of diabetics, life with diabetes,, Book Clear Michalovce ISBN 978-80-9711629255 .2012, pp. 67
6. SILHAROVA B, SUVADA J, FRANEKOVA M, NOGE A, MIKOLASOVA G: Malaria in hyperendemic region, Neuroendocrinology Letters. 34, 2013, s1 38-43

Highland malaria at the Kiziba UNHCR refugee camps (1950 m. a. s.)

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High CRP correlates highlands malaria.

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Abstract:

Introduction: Risk factors for highland malaria and difference diagnosis of highland malaria is discussed and analyzed in UNHCR refugee camps in Kiziba, Rwanda.

Patients and Methods: Diagnosis of highland malaria was performed clinically plus microscopically (blood smear) and with rapid diagnostic test (RDT).

Results: 371 patients from an area of 4,777 residents were diagnosed for malaria and the mean levels of CRP were 70.1 g/l.

Conclusion: Despite Highland malaria at an altitude of 1,950 m.a.s. is very rare, CRP response in a patient was significant.

Introduction

Highland malaria has after a subclinical, clinical course and sub-microscopical laboratory presentation chronic mild symptomatology, therefore is difficult to diagnose and only a few patients receive appropriate therapy (1-3). Chronic diseases with liver involvement especially in *P. vivax* malaria is not uncommon even at a height of 2,000 m.a.s. (4-8). C-reactive protein is usually elevated but slides remain negative; rapid tests (RTD) and PCR are however positive (9-12). The aim of this research was to assess diagnosis treatment and burden of the disease (occurrence) of highlight malaria in UNHCR refugee population of a Rwandan refugee camp.

Patients and Methods:

We were using data from HMIS which is a surveillance document for monthly reporting unified by Rwandan Ministry of Health, which all healthcare facilities in the country are obliged to provide at the end of month and which is created by calculation of the nurse who occasionally undergoes trainings on how to collect data. In our Health Center in Bigugu this job was done by one person and afterwards it was rechecked by another employee of ours in order to ensure the reliability of our data. In the remaining two health facilities, where we couldn't ensure this double check, we also checked the accuracy of those reports by comparing data from books held by expert laboratory technicians, who are obliged to register every malaria positive case. In all health centers of our interest, laboratory technicians have attended on a regular basis attending training in order to improve their qualification.

Patients were examined for tropical malaria by microscopic examination using thick blood film stained by Giemsa in 95% - 98% of all malaria positive cases. In case of an absence of an expert laboratory technician

or during the weekends, PhHRP2 based malaria rapid tests were used by a trained nurse. Tests were stored according to manufacturer's recommendation at 25°C, protected from sunlight and humidity and no test was used after its expiry date. In two out of three health centers, where use of a mosquito net is the gold standard, we also collected data regarding mosquito net distribution. We used Pearson's correlative coefficient in order to determine correlation between the prevalence of malaria in the Kiziba Health Center and Kibuye Health Center.

Results: Description of the catchment area

The longitudinal prospective quantitative study that began in February 2013 and ended in July 2015 was conducted at the Bigugu Health Center. BHC is a health facility which is located at the Rwankuba Sector, Karongi district, Western Province of Rwanda. The area of the study is localized at the altitude of 2,250 meters above sea level and belongs to an area with very low or no malaria transmission areas at all. Bigugu Health Center is a healthcare facility for the total population of 17,000 inhabitants. The majority of this population (93%) as simple peasants earn their living by cultivating in their tiny field staple crops like beans, maize and potatoes. Due to their daily activities as well as the poor quality of their housing, they are constantly exposed to the mosquito bites, relying mainly on the fact that this area used to be too cold and unsuitable for breeding of mosquitos. 371 patients of varying age (8 months - 77 years) with suspected malaria over this period were examined also for the level of CRP.

Patients with typical presentation of other infectious diseases than malaria itself that can alter CRP (cough, symptoms of urinary respiratory infections or symptoms of gastroenteritis) were excluded from the study, as well as those who had in their medical

histories travelled in the area of a lower altitude in the previous 30 days, as well as patients on steroids or other immunosuppressants. Only patients presenting with headache accompanied with elevated body temperature or history of fever in the previous three days as well as abdominal pain without diarrhea in child patients were included. Those patients were examined for tropical malaria by microscopic examination and occasionally (in 47 out of a total of 371 patients) double checked by PhHRP2 based malaria rapid tests. 371 cases suffering from highland malaria were also examined for CRP using the NycoCard Reader II Machine. All CRP tests were stored in the refrigerator according to the instructions of a manufacturer and no test was used after the expiry date. All samples collected over the time were examined by the same person, an expert laboratory technician at the Bigugu Health Post. Retrospective quantitative study collecting and comparing data from January 2012 - July 2015 was performed at three health centers at the Karongi District of Western Rwanda.

Bigugu Health Center, Kiziba Health Center and Kibuye Health Center, which are localized at different altitude (2,250 asl, 1,950 asl and 1,450 asl retrospectively) cover a catchment area for a population comparable in size (17,000 in Bigugu, 19,500 in Kiziba and 24,000 at the Kibuye Health Center). The difference in the size of the population wasn't important for our research as we compared the number of malaria positive cases against the total number of OPD patients; calculating the prevalence of malaria out of it. While in the BHC catchment area the majority of the population do work as peasants (93%), in the KzHC catchment area most of the population consists of refugees. The majority of the refugee population do not have any job and migrate a lot to the lower KbHC area in order to trade their food for other needed

goods, though it is uncommon to spend the night there. In the KbHC area many people work in the third sector though unfortunately exact numbers are not available. For those people it is much more common to travel by bus towards the direction of the capital Kigali where malaria is more prevalent.

Secondary Data and Document Review

This method involved studying the varying and relevant written and published studies on issues of climate variability and impacts on malaria, vulnerability and adaptation of communities. It consists of data and any information obtained from other sources to act as a back-up on what has been found in the field. Secondary data help in supporting an argument since it offers justifications for the choice of topic. We reviewed all available articles written in English language on topic of either climatic change in Rwanda or climatic change and its effect upon malaria transmission in Rwanda which were published since 2004.

Data analysis

A) After collecting the data, we determined the mean level of CRP for each year separately, as well as the mean CRP in total. We determined the mean CRP level as a proportion of the sum of all CRP values to the number of all measured patients. In total, among 371 investigated malaria positive patients had an average CRP value of 70.6. 34 cases had a CRP level in values between 8-25 mg/l; 79 cases in values between 25-50 mg/l; 88 cases in values between 50-75 mg/l; 77 cases in values between 75-100 mg/l; 36 cases in values between 100-125 mg/l; 27 cases in values between 125-150 mg/l; 20 cases in values between 150-175 mg/l; 10 cases in values between 175 -200 mg/l. Out of 371 malaria positive patients no one had a CRP level higher than 200 mg/l.

The distribution of CRP levels in malaria positive patients admitted to the Bigugu Health Center in period 12/13-07/15. The mean CRP levels in patients suffering from highland malaria were analyzed separately each month. In those patients where malaria was confirmed not only by microscopy but also by using RAPIDs, out of 47, 44 were positive and 4 results were invalid but we did not repeatedly perform the examination in order to avoid unnecessary unpleasant procedures.

B) We calculated the prevalence over the time separately for each month. The prevalence was calculated for each health center as the number of malaria positive cases divided by the total number of patients attending OPD. Results were put into graphs, from which the following is obvious: The prevalence in each investigated health center increased multifold. The higher the altitude of the health center, the more significant the increase of malaria was observed. Regarding mosquito net distribution, while for Kiziba HC Pearson's correlative coefficient was negative -0.00541; at Kibuye HC Pearson's correlative coefficient was 0.11237; which means a positive correlation between number of distributed mosquito nets and number of malaria positive cases.

Discussion

The results of our study show that in the patients suffering from highland malaria the levels of CRP are significantly elevated, however, more voluminous studies of this topic are required as our study was limited by relatively small sample (1-3). We also suspect that in people repeatedly suffering from the attack of malaria (non-highland malaria) the values of CRP won't be so high as the response from the partially adjusted immune system isn't expected to be so aggressive. We also noticed that the value of CRP values even in BHC during last three years is slightly decreasing what is also in accord with our theory and it could be very interesting

topic for another research (4-8). As in the second part, our results point at that malaria is on the rise and in case of the malaria outbreak in Rwanda, people living in the highlands are more endangered. The increase of prevalence is more prominent the higher altitude. The explanation behind it might be a missing partial immunity against malaria. The explanation behind increased prevalence offered by the Rwandan Government is the low quality of donated mosquito nets or deficient impregnation on them (9-12).

Conclusions

Results of this study do prove that highland malaria has strong positive correlation with elevated value of C-Reactive Protein. Data from three health facilities in western Rwanda are all pointing out that malaria in this country is on the rise and this upsurge in malaria is even more significant than statistical data released by the Rwandan Government suggests. Also the review of the multiple documents researching the climate change in Rwanda are in accord, suggesting that global warming contributes just very little or not at all to this enormously increased incidence of malaria in the Karongi District in Western Rwanda. Necessary precautions like mosquito nets distributed to all people independently of the altitude they live at should be undertaken to stop this malaria spreading in Rwanda.

We reviewed seven relevant articles which were researching any connection between climatic change and rising malaria incidence. Though some authors very vaguely suggested that 'The results of this study indicate that future climate might become more suitable for malaria transmission in the tropical highland regions.' However, adding cautiously that other important socioeconomic factors such as land use change; population growth; urbanization; migration changes; economic development will have to be accounted for in further details for future risk

assessments without any attempt to quantify their findings, most authors were in accord, that it should be recognized that changes in malaria are unlikely to be a major contributor to modifications in the total burden of disease owing to global climate change [42].‘

However, most important for our research is without any doubt an article saying:

A physically nearly unchanged regional climate zone is the area along Lake Kivu. The already-mentioned local climate peculiarity arising from the prevailing land-lake-wind circulation continues to cause climatic conditions that remain roughly the same, with slightly rising temperatures (+0.5 K) and a decrease in rainfall of around 50 mm. While the area in southern Rwanda, especially around the Nyungwe Rainforest, exhibits modest temperature changes (+0.5 K) and continues to register rainfall totals of >1,400 mm, around the Virunga Volcanos the temperatures range about 2 K higher while total rainfall has clearly dropped (-250 mm) [18].

This basically says that there was no climate change in the area of our interest as both Lake Kivu and Nyungwe Forests work as kind of buffers. In other words, whatever went wrong in the fight against malaria in Rwanda, to blame global warming for it is just an alibi.

References

1. MUPFASONI D, KARIBUSHI B, KOUKOUNARI A, RUBERANZIZA E, KABERUKA T *et al.*: Polyparasite Helminth Infections and Their Association to Anemia and Undernutrition in Northern Rwanda. *PLoS Negl Trop Dis* 3(9): e517, 2009
2. HRUZIK J *et al.*: *Infektológia, OSVETA*, 1984, pp 355
3. RAJČÁNI J, ČIAMPOR F: *Medical Virology, VEDA*, 2006, pp 420
4. HRUBIŠKO M.: Rationale of therapy of Respiratory tract infections. *Ambulantná terapia*, 2/2007, 133 pp.
5. DJAČENKO SS, SINJAK KM, DJAČENKO NS: *Pathogenic human viruses. AVICENUM, Praha* 1980,
6. World Health Organization: *World Malaria Report 2015*, ISBN 978 92 4 156515 8, 2015
7. THE GLOBAL FUND, *Results Report 2015*, ISBN 978 92 9224 435 4, 2015
8. BEDNÁŘ M, a kol.: *Lékařská mikrobiologie, MARVIL*, 1996
9. BELL D R: *Lectures notes on Tropical Medicine, Fourth edition*, 1995
10. President's Malaria Initiative: *Malaria Operational Plan, Rwanda FY 2015*,
11. President's Malaria Initiative: *Malaria Operational Plan, Rwanda FY 2013*,
12. WORLD HEALTH ORGANIZATION: *World malaria report 2014*, ISBN 978 92 4 156483 0, 2014
13. CHAVES LF & KOENRAADT CJM: *Climate change and highland malaria: fresh air for a hot debate. The Quarterly review of biology*, 85 (1), 27-55. , 2010
14. HIMEIDAN YE, KWEKA EJ: *Malaria in East African highlands during the past 30 years: impact of environmental changes*, *Front Physiol.* Aug 2;3:315, 2012
15. AASE A, HABARUGABA G: *Malaria invading the highlands of Africa: Global warming or local environmental change? Acta Geographica - Trondheim. Series B.No.11.*, 2006
16. ABUDA C: *An Assessment of the impact of climate variability on malaria in Uganda.*, Master Thesis, Department of Geography, Norwegian University of Science and Technology, Trondheim, Norway, 2012
17. LINDSAY SW, MARTENS WJ: *Malaria in the African highlands: past, present and future*, *Bull World Health Organ.* 76(1):33-45., 1998
18. HENNINGER SM: *Local climate changes and the spread of malaria in Rwanda*, *Health*, Vol.5 No.4, 2013
19. LOEVINSOHN ME: *Climatic warming and increased malaria incidence in Rwanda* *Lancet*, Mar 19;343(8899):714-8., 1994

20. KAPPAS M: *Klimatologie. Klimaforschung im 21. Jahrhundert: Herausforderung für Naturund Sozialwissenschaften*. Spektrum Akademischer Verlag, Heidelberg, 2009
21. COENE J: Malaria in urban and rural Kinshasa: The entomological input. *Medical and Veterinary Entomology*, 7, 127-137, 1993
22. SIEBERTZ K, van Bebbber D, Hochkirchen T: *Statistische versuchsplanung*. Springer Verlag, Berlin, 2010
23. UNITED NATIONS General Assembly. *International Development Strategy for the Second United Nations Development Decade*, paragraph 43. UN, 1970
24. MILLER JM., KORENROMP EL, NAHLEN BL, Steketee R: Estimating the number of insecticide-treated nets required by African households to reach continent-wide malaria coverage targets, *Journal of the American Medical Association* 297 (20): 2241–50, 2007
25. NOOR AM, MUTHEU JJ, TATEM AJ, HAY SI, SNOW RW: Insecticide-treated net coverage in Africa: Mapping progress in 2000–07 *Lancet* 373 (9657): 58–67, 2009
26. UNICEF, WHO: *Achieving the malaria MDG target: reversing the incidence of malaria 2000-2015*, ISBN 978924150944 2, 2015
27. SCHLAGENHAUF-LAWLOR P: *Travelers' Malaria*, p. 215, BC Decker Inc, Hamilton, Ontario, 2008
28. WORLD HEALTH ORGANIZATION: *Instructions for treatment and use of insecticide-treated mosquito net*, p. 34, 2002
29. ENAYATI A, HEMINGWAY J: Malaria management: Past, present, and future". *Annual Review of Entomology* 55: 569–91, 2010
30. WORLD HEALTH ORGANIZATION: *World Malaria Report 2014*, ISBN 978 92 4 156483 0, 2014
31. WORLD HEALTH ORGANIZATION: *WHO Position Statement, Indoor Residual Spraying: Use of Indoor Residual Spraying for Scaling Up Global Malaria Control and Elimination*, 2006
32. VAN DEN BERG H: Global status of DDT and its alternatives for use in vector control to prevent disease, *Environmental Health Perspectives* 117 (11): 1656–63, 2009
33. PATES H, CURTIS C: Mosquito behaviour and vector control, *Annual Review of Entomology* 50: 53–70, 2005
34. TUSTING LS, THWING J, SINCLAIR D, FILLINGER U, GIMNIG J, BONNER KE, BOTTOMLEY C, LINDSAY SW: Mosquito larval source management for controlling malaria, *Cochrane Database of Systematic Reviews* 8: CD008923, 2013
35. LALLOO DG, OLUKOYA P, OLLIARO P: Malaria in adolescence: Burden of disease, consequences, and opportunities for intervention, *Lancet Infectious Diseases* 6 (12): 780–93, 2006
36. LAWSON JB, HARRISON KA, STAFFAN BERGSTROM S: *Maternity care in developing countries*, chapter Malaria in pregnancy, RCOG Press, 2001
37. WICZMANDYOVA D, MURGOVA A, *The life of diabetics, life with diabetes*, Book Clear Michalovce ISBN 978-80-9711629255 .2012, pp 67
38. THE REPUBLIC of RWANDA, MINISTRY of HEALTH: *Rwanda Annual Health Statistics Booklet 2014*
39. BARTOLONI A, ZAMMARCI L: Clinical aspects of uncomplicated and severe malaria, *Mediterranean Journal of Hematology and Infectious Diseases* 4 (1): e2012026, 2012
40. WALKER BR, COLLEDGE NR, RALTSOHN SH: *Davidson's Principles and Practice of Medicine*, 21st edition, p 351, 2010
41. WARHURST DC, WILLIAMS JE: Laboratory diagnosis of malaria, *J Clin Pathol* 49 (7): 533–38, 1996
42. SILHAROVA B, SUVADA J, FRANEKOVA M, NOGE A, MIKOLASOVA G: Malaria in hyperendemic region, *Neuroendocrinology Letters*. 34, 2013, s1 38-43

A case report of dual infections: infection due to mycobacterium tuberculosis and mycobacterium marinum in a migrant child from Lybia to Sicily

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Case

Six year old Chadian born boy was rescued with his family after a 6 days trip in an open vessel along with 80-100 refugees from Darfour, Chad, Niger, Mali, Eritrea, Sudan, Somalia and Ethiopia(1-3). The rescue team within operation "Mare Nostrum" landed in Sicily and basic investigation screening was done on site. Because of malnutrition (BMI <17) fever and coughing, the family including the boy was scanned by regular chest X-ray and Gene-X-pert PCR type method for MTB was performed and was positive. The family was quarantined and sputum culture was positive microscopically for *M. tuberculosis*. Cultivation was ordered and two organismus grew in the culture, *Mycobacterium marinum* in 3rd week and *M. tuberculosis* in a second culture in 6th week (HIV,

diabetes or cancer were excluded (4,6,7)). Anti-TB Therapy with rifampin (both susceptible) pyrazinamid, isoniazid plus azithromycin were adjusted for 3 month however the family left quarantine after three months resulting in a loss of follow up. We assume that the child had an old M-tuberculosis infection which spread during his travel from Chad to Libya; than waiting for another two weeks in overcrowded conditions in a Libyan transit "village"; then the boat ride to get infected by an aquatic atypical mycobacterium either from bad water and substandard hygiene on the vessel; or at rescuing process from the sea (2-4). Loss of follow up is one of the major problems in therapy for those refugees who leave quarantine facilities legally or illegally (1) to travel to relatives in other EU states.

Screening for TB, HIV and hepatitis C, and also probably for (chronic) malaria is crucial for refugees in the so called African - Malta - Italian Route through the Mediterranean Sea (1).

Location respiratory or skin manifestation of TB is easy to screen (1-3); by questionnaire for those with cough, fever, night sweats, weight loss; positive by chest X-ray; or suspected individuals positive by rapid test (Gene X- pert MTB/RIF); if positive, supervised chemotherapy for 6-months; up to 3-4 anti-TB of tests, because no real screening tests are available (3-6).

The problem is lack of screening for other than TB mycobacteria or other marine bacteria (*Vibrio vulnificus* etc.) (1) and malaria (4-5)

There are no available screening methods for those more rapid growing pathogens and only prolonged quarantine or supervision can help us to diagnose and properly treat those infectious diseases in refugees or “economic migrants from “ the African continent (1,3,4).

References

1. PRESTILEO T, DI LORENZO F, CORRAO S: Infectious Diseases among African irregular migrants in Italy. Just an individual problem? *Clin. Soc. Work* 2015, 5, 45
2. GÚTH, A. 2015: Pes a rehabilitácia In: *Rehabilitácia* ISSN 0375-0922, Vol. 52, 2015, No 3, p. 130
3. KOLÁŘOVÁ, B., KROBOT, A., HABERMANNOVÁ, P., KOLÁŘ, P., BASTLOVÁ, P. 2015: Využití představy a observace pohybu v kognitivní a pohybové rehabilitaci In: *Rehabilitácia* ISSN 0375-0922, Vol. 52, 2015, No 3, p. 131-139
4. KRCMERY V., KALAVSKY E: Antibiotic Resistance in “ATB free” environment. In *Neuroendocrinology Letters*, 2007, 28, 83, p 33-34.
5. WICZMANDYOVA D, TKACOVA L, MURGOVA A: Proceedings. *Slov. Med. Univ.: The Socio Economic aspect of Migrations*, ISBN 978-80-89352-47-0, pp 62-70
6. PUTEKOVA S, KABATOVA O: Nursing care for migrants in a refugee camp: *Clin. Soc.Work, Health Intervention*. 6. 2016.1, 73
7. SILHAROVA B, SUVADA J, FRANEKOVA M, NOGE A, MIKOLASOVA G: Malaria in hyperendemic region, *Neuroendocrinology Letters* 34, 2013, s1 38-43
8. SUVADA J, CZARNECKI P, TOMANEK P, JANKECHOVA M *et al.* *Social Pathology*. Warszav, 2015, pp 450
9. WICZMANDYOVA D, MURGOVA A: The life of diabetics, life with diabetes,, *Book Clear Michalovce* ISBN 978-80-9711629255 .2012, pp 67.

Accidental Cymoxanil (TANOS) pesticide poisoning (Case report)

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Original Articles

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Key message

Unusual case of a poisoned child.

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Abstract:

Background: Pesticides are a group of chemicals used in agriculture in order to achieve higher and better-quality crops. The vast majority of these are synthetic substances whose effect on the human organism is unfavorable, even toxic.

Methods: We provide a brief overview of available Slovak and world literature on these issues. In the next section, we deal with the case of a patient, whose leading symptoms were headache and behavioral changes. After excluding organic lesions, we made a diagnosis „per exclusionem“ and diagnosed cymoxanil poisoning.

Conclusions: We consider the relatively low number of recorded poisonings to be a result of strict regulation of pesticide use.

Introduction

Pesticides are chemicals used to protect vegetables against animal pests, fungi and weeds. These are organic or inorganic substances. They are applied as a spray, powder, granules or mordant. The most important pesticides are insecticide substances used for destroying insects; fungicides - substances used to destroy harmful parasitic fungi; herbicide - substances used for weed control; rodenticides - substances used for destroying rodents¹. (1)

If one uses pesticides it is important to work with extreme caution. How to use them and health at work are regulated by provisions having the force of law^{2,3}.(2-3)

TANOS 50WG is a combined two-component fungicide to protect potatoes against potato blight and potato Alternaria leaf spot, tomatoes against potato blight; cucumbers and zucchini against cucumber Peronospora; vines against Peronospora. Active substance: cymoxanil 250g/kg + famoxadone 250g/kg. Formulated as: dispersible granule Mechanism of action: systemic and contact.

Antracol Combi WP 76 is a combined two-component fungicide intended for plant care, with a spectrum of activity similar to the product TANOS 50WG. Active substance: propineb 70% + cymoxanil 6%. Formulated as: dispersible powder⁴.

Characterization of cymoxanil: Chemical characterization: N-ethylaminocarbonyl-2-cyano-2-methoxyiminoacetamide. The substance belongs to the class of acylureas. It acts primarily in systemic, but partly also in contact, fashion on plants. The effects of cymoxanil in plants include inhibition of nucleic acid synthesis, reduction in the permeability of cell membranes, limiting respiration and disruption of serine, glycine and cysteine synthesis. This results in inhibition of mycelial growth, reduction of sporulation and spores germination⁵.

Symptoms of cymoxanil poisoning are presented in Table 1.

Case description

A 50-year-old, otherwise healthy man was brought into the internal medicine emergency room with a headache lasting 4 days and body temperature up to 38 °C. Beside the headache he complained about dry mucous membranes of the mouth, loss of appetite, fatigue, increased sweating, also at night. Targeted questions specified that four days before admission, i.e. before symptoms started, he sprayed vegetables against fungi. He could not specify the product name. During the spraying he was exposed to direct sunlight and despite knowledge of safety he did not use any respirator.

The symptoms started the next morning and persisted during the consultation with a doctor.

Objective finding reads that the patient was obese (BMI 33), skin was sweaty, body temperature 36.5 °C, isocoric pupils in middle position, bulbs without nystagmus, injected conjunctiva. Overall, psychomotor restlessness was present. The patient was restless & fussed to find a relief position. Neither neurological focality nor laterality were observed. Signs of meningeal irritation were indicated. The laboratory tests showed neutrophilic leukocytosis, adequate coagulation parameters, a high level of C-reactive protein, a normal procalcitonin, slightly increased GMT activity (Table 2).

CT scan of the brain + skull trauma program were indicated. The finding was negative.

The condition was evaluated as susp. Meningitis. We indicated parenteral antibiotic therapy. We examined the eye-ground with age-appropriate findings. The patient was IV hydrated and orally hydrated at the same time. During hospitalization the body temperature repeatedly exceeded 38 °C, we took a blood culture but it was completed with negative results.

Family members delivered packaging of the spraying used. It was a TANOS preparation (active substances: cymoxanil + famoxadone). From the available literature we found that symptoms may indicate a cymoxanil poisoning.

Tests for focal infection were conducted. Echokg, dental and ENT findings were normal. The eyeground finding was negative.

Hydration, antibiotic, anti-edematous (mannitol) and analgesic treatment continued. The patient's condition gradually improved. On the fifth day he was in good condition released to outpatient care.

Discussion

In available Slovak and world literature there is a minimum of described cases of accidental pesticide poisoning. Searching through Medline, apart from two case reports, we found only descriptions of the results of laboratory experiments and monitoring of workers^{6,7,8}.(6-8). There are mainly articles describing the effects of these substances in the laboratory or in experiments.

The low number of accidental poisonings may be a result of very strict regulatory measures which the workers with pesticides are obliged to observe⁹.(9). In the USA, for the period from 1988 to 2005, 3,271 cases of pesticide poisoning were recorded. Of these, 20 were severe¹⁰. Unfortunately, we could not find data from the Slovak Republic.

The diagnosis of „poisoning Cymoxanil“ was determined *per exclusionem*, after excluding other possible diseases such as meningitis, focal infection, disruption of the internal environment, CNS tumor or stroke. (10-11). From the available literature, we found that there is no specific treatment for cymoxanil poisoning. We followed the recommendations and the patient was administered supportive, anti-edematous and eliminating treatment.

Conclusion

Using only products which are mentioned in the list of registered and permitted pesticides¹¹ and using the prescribed personal protective means virtually eliminates the possibility of damage to human health.

The poisoning, also described in this case, occurred due to a failure to observe safety measures – to use personal protective equipment.

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References

1. KEGLEY SE, HILL BR, ORME S, Choi AH: *PAN Pesticide Database*, Pesticide Action Network, North America (Oakland, CA, 2014). Available from: <http://www.pesticideinfo.org>
2. Act of the National Council of the Slovak Republic No. 405/2011 Coll. on Phytosanitary Care (In Slovak)
3. Ministry of Agriculture and Rural Development of the Slovak Republic. The National Action Plan to Achieve the Sustainable Use of Pesticides. (in Slovak) Available from: <http://www.mpsr.sk/index.php?start&navID=1&id=6985>
4. HAYES WJ Jr., LAWS ER Jr., Editors. Handbook of Pesticide Toxicology. Volume 2. Classes of Pesticides. New York, NY: Academic Press, Inc., 1991.
5. PHYTOPATHOLOGY BASICS. Katedra botaniky Přírodovědecká fakulta UP v Olomouci. (In Czeck) Available from: <http://isb-up.cz/data/PDF/ZFP/Zaklady-fytopatologie-7.pdf>
6. TITLIC M, JUKIC I, TONKIC A, PUNDA A: Headache caused by handling the pesticide Antracol Combi WP 76: a case report.

- J Headache Pain. 2007;8(6):345-7. Epub 2007 Dec 10.
7. KOCH P: Occupational allergic contact dermatitis and airborne contact dermatitis from 5 fungicides in a vineyard worker. Cross-reactions between fungicides of the dithiocarbamate group? Contact Dermatitis. 1996;34(5):324-9.
 8. HOYOS LS, CARVAJAL S, SOLANO L, RODRIGUEZ J, OROZCO L, LOPEZ Y, Au WW. Cytogenetic Monitoring of Farmers exposed to pesticides in Colombia. Environ Health Perspect 1996;104 Suppl 3:535-8.
 9. DAVANZO F, SETTIMI L, FARAONI L, MAIOZZI P, TRAVAGLIA A, MARCELLO I. [Agricultural pesticide-related poisonings in Italy: cases reported to the Poison Control Center of Milan in 2000-2001].(In Italian) Epidemiol Prev. 2004;28(6):330-7.
 10. CALVERT GM, KARNIK J, MEHLER L, BECKMAN J, MORRISEY B, SIEVERT J, BARRETT R, LACKOVIC M, MABEE L, SCHWARTZ A, MITCHELL Y, MORAGA-McHALEY S: Acute pesticide poisoning among agricultural workers in the United States, 1998-2005. Am J Ind Med. 2008;51(12):883-98.
 11. SILHAROVA B, SUVADA J, FRANEKOVA M, NOGE A, MIKOLASOVA G: Malaria in hyperendemic region, Neuroendocrinology Letters 34, 2013, s1 38-43
 12. KEIFER M, GASPERINI F, ROBSON M.: Pesticides and other chemicals: minimizing worker exposures. J Agromedicine. 2010;15(3):264-74.

Tab. 1 Symptoms of cymoxanil poisoning

Mild	eye irritation, allergic skin exanthema
Moderate	headache, nervousness, visual impairments, asthenia, nausea, muscle cramps, diarrhea, discomfort in the chest, miosis, sialorrhoea, gasping, vomiting, cyanosis
Severe	convulsions, disturbance of consciousness up to coma, hyporeflexia up to areflexia, plegia of sphincters, cardiac arrhythmia, cardiac arrest

Tab 2 Lab test values of the patient

Parameter	Unit	04.07.2015	05.07.2015	06.07.2015	07.07.2015
FW	mm		12/20		
Blood count					
Leucocytes	10 ³ /uL	15.5			14.2
Erythrocytes	10 ⁶ /uL	5.21			4.13
Haemoglobin	g/L	164			130
Hematocrit	ratio	0.46			0.38
Thrombocytes	10 ³ /uL	204			171
Coagulation					
PT	INR	1.23	1.22		
aPTT	ratio	1.11	1.08		
Fibrinogen	g/L	2.43	2.38		
D-dimer	ug/ml FEU	0.27			
Biochemistry					
Glucose	mmol/L	7.47			
Urea	mmol/L	7.3			3.4
Creatinine	umol/L	124			110
Uric acid	umol/L	485			
Proteins	g/L	81.7			67.2
Albumin	g/L	49.9			41.5
Total bilirubin	umol/L	23.4			9.6
Dir. bilirubin	umol/L	3.8			
AST	ukat/L	0.32			0.21
ALT	ukat/L	0.59			0.40
GMT	ukat/L	1.38			1.03
ALP	ukat/L	1.08			0.95
Cholinesterase	ukat/L	215.14			
Cholesterol	mmol/L	6.01			4.31
HDL-Chol	mmol/L	0.77			0.77
LDL-Chol	mmol/L	3.01			
Triglycerides	mmol/L	2.66			2.66
AMS	ukat/L	0.72			
Natrium	mmol/L	132.3			138.7
Kalium	mmol/L	4.2			4.0
Calcium	mmol/L	2.56			2.2
Chlorides	mmol/L	97.2			101.9
Phosphorus	mmol/L	0.85			0.99
Magnesium	mmol/L	0.97			0.98
CRP	mg/L	1.1			73.7
Procalcitonin	ng/mL	under cut-off			under cut-off
Troponin I	ng/mL	under cut-off			
NT-pro-BNP	pg/mL	under cut-off			
IgE	IU/mL	136.6			

Experience with migrants on Balkan Route from the Field Hospital on the Slovenian-Croatian Border

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Few transmissible diseases in migrants from Greece to Central Europe.

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Abstract:

Aim of the Study: Balkan Route for Syrian and Iraqi refugees started on September 6, 2015 and ended on March 2, 2016 and it took 7 months for 1,190,000 people to migrate from those war and conflict areas. The aim of the study was to assess the spectrum of diseases in the population of migrants in 2015/2016.

Patients and Methods: A total of 6,142 refugees from Iraq, Syria and Afghanistan visited our field hospital in Dobova on the Slovenian-Croatian border; 4,111 were children. The spectrum of diagnoses and screening tests in suspect cases were assessed.

Results: Majority of the patients did not suffer from any tropical disease; no new case of TB was detected; all the tests for HIV, Hepatitis

B and C were negative. The spectrum of disease was similar to the one of the host country, i.e. depression, diarrhea, respiratory tract infections and chronic diseases, such as asthma and coronary artery disease in the elderly were common.

Conclusion: Refugees migrating through the Balkan Route from Syria, Iraq and Afghanistan through Turkey and Greece have very similar epidemiological characteristics as the host population. No outbreaks and no sporadic transmissible diseases were reported in the period from September 2015 till March 2016 in this group of migrants from the Middle East.

Introduction

The refugee crisis in European Union (EU) started with the so-called African-Mediterranean Route from Libya to Italy and Malta, where since 2004, every year in total of 250,000 migrants, most of them being “economic” migrants, crossed the Mediterranean Sea to European Union (i.e. 3 million migrants in total). The Balkan Route for Syrian and Iraqi refugees started on September 6, 2015 and ended on March 2, 2016 and it took 7 months for 1,190,000 people to migrate from those war and conflict areas. (1-2). The aim of the study was to assess the spectrum of diseases in the population of migrants in 2015/2016.

Patients and Methods

Among about 150,000 migrants who took the Route from September 6th until March 6th when the transports through Croatia, Serbia and Macedonia were suspended 6,142 migrants sought medical help at the St. Elisabeth Field Hospital in Dobova on Slovenian-Croatian Border. The Field Hospital included 4 physicians, 4 rescue staff, 2 nurses, 4 social workers, drivers and logisticians. Medicines and tests for screening (HIV, Hepatitis B and C, swabs for rectal and respiratory pathogens) were provided by St. Elisabeth Laboratory of Molecular Diagnostics.

Results and Discussion

Table 1 presents the commonest diseases diagnosed and presented to the Slovak staff

from September 6, 2015 till March 2, 2016. Among the transmissible diseases were 626 cases scabies; 299 cases lower RTI (Respiratory Tract Infections) with reported (predominantly pediatric pneumonia); 632 cases upper RTI (both in children and adults) reported. No case of TB or other epidemiologically important diseases such as typhoid fever, Hepatitis A and B, HIV typical for such regions was reported. The majority of sick refugees suffered from a chronic disease related to long-term conflict, war, displacement such as asthma, hypertension, depression, which were responsible for >50% of all visits at the Out-patient Department of the Field Hospital of the St. Elisabeth Tropic Team in Dobova on Slovenian-Croatian Border. Similarly to our patients in Dohuk and Erbil (refugees from Mosul to Kurdistan) (2) or Hegyesalom-Nickelsdorf (HU-AU) checkpoint with 612,00 migrants crossing to Austria, where no outbreak of transmissible/ tropical/infectious disease was observed (1-4).

Conclusion

The Balkan Route for Syrian and Iraqi refugees started on September 6, 2015 and ended on March 2, 2016 and it took 7 months for 1,190,000 people to migrate from those war and conflict areas. The aim of the study was to assess the spectrum of diseases in the population of migrants in 2015/2016. A total of 6,142 refugees from Iraq, Syria and Afghanistan visited our field hospital in Dobova on Slovenian-Croatian border;

4,111 were children. The spectrum of diagnoses and screening tests in suspect cases were assessed. The majority of the patients did not suffer from any tropical disease; no new case of TB was detected; all the tests for HIV, Hepatitis B and C were negative. The spectrum of disease was similar to the host country, i.e. depression, diarrhea, respiratory tract infections and chronic diseases, such as asthma and coronary artery disease in the elderly were common. Refugees migrating through the Balkan Route from Syria, Iraq and Afghanistan through Turkey and Greece have very similar epidemiological characteristics as the host population. No outbreaks and no sporadic transmissible diseases were reported in the period from September 2015 till March 2016 in this group of migrants from the Middle East.

2. ALJOUNI, KAMEL *et al.*: Refugees in the eastern Mediterranean region. *The Lancet*, Volume 386, Issue 10012, 2476 – 2477
3. WICZMANDYOVA D, MURGOVA A, *The life of diabetics, life with diabetes*, Book.Clar Michalovce ISBN 978-80-9711629255 .2012, pp 67.
4. WICZMANDYOVA, D, TKACOVA, L, MURGOVA, M: *Proceedings Slov. Med. Univ.: The Socio Economic aspect of Migrations*, ISBN 978-80-89352-47-0, pp 62-70
5. SUN YS, ZHAO XY, ZHANG BK, JIANG JF, LU HJ, CAO YX, WU GZ, QIAN J, SUN Y, ZENG YJ: Practices and thinking of laboratory detection in the aid to West Africa to fight against Ebola. *Bratislava Medical Journal* Vol.117, No.5, p.254-257, 2016. doi:10.4149/BLL_2016_049.

Tab 1. Commonest diseases among 6,142 refugees from Middle and Far East to EU via Balkan Route seen from September 6th, 2015 till March 2nd, 2016 In Dobova Field Hospital.

Diagnosis	Number of patients
Upper RTIs	632
Lower RTIs	299
Congelatio	201
Skin parasites (scabies)	626
Coronary artery disease	716
Hypertension	1,346
Asthma	614
Diabetes mellitus	299
Depression	1,106
Total number of patients	6,142

References

1. ESCOBIO, FAVILA *et al.*: Health assistance of displaced people along the Balkan route. *The Lancet*, Volume 386, Issue 10012, 2475
6. SILHAROVA B, SUVADA J, FRANEKOVA M, NOGE A, MIKOLASOVA G: Malaria in hyperendemic region, *Neuroendocrinology Letters* 34, 2013, s1 38-43

Antibiotic susceptibility of respiratory isolates among HIV-positive children in Kyrgyzstan is higher compared to those Cambodia: Is outpatients status important?

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Key words:

HIV-AIDS, HAART.

Key message:

ATB resistance mainly in *S. aureus* was higher in HIV children in Cambodia.

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Abstract:

Introduction: The aim of the study was to compare resistance rate against anti-retrovirals in two cohorts of children with HIV - one perinatally infected from Cambodia and the other nosocomially infected in Kyrgyzstan.

Patients and Methods: Two groups of HIV positive children were compared: Vertically infected Khmer children in Cambodia and nosocomially infected children in 3 hospitals in Kyrgyzstan.

Results: Prevalence of *S. aureus* and other oral cavity comensal was much lower in Kyrgyz children in comparison to Khmer children in

Cambodia due to type of treatment with HAART (inpatients versus outpatients).

Conclusion: In inpatient setting of HIV positive children, ATB resistance is lower.

Introduction

Viral, parasitic, bacterial and fungal co-infections are very frequently present among HIV positive children and such conditions often require administration of antibiotics during their therapy (1-2). The spectrum of infections occurring in HIV positive children is wide and use of antibiotic prophylaxis can stimulate development of resistance (3-4). We aimed to evaluate the spectrum of infections among pediatric HIV patients receiving HAART (Highly Active Retroviral Therapy) and to assess resistance rates of those microorganisms in the two groups of children with HIV.

Methods

Samples obtained from 51 HIV-positive children from Osh, Bishkek, Jalal-Abad, Kara-Suu and Nookatsk, Kyrgyz Provinces who have been receiving HAART for 3 years, were included. During their previous hospital stays, children were frequently treated with ampicillin. Cultivations from samples were performed and antibiotic profiles were assessed. A group of 51 children from Kyrgyzstan was compared to 141 children from Phnom Penh and Sihanoukville. Cambodia has a 15 year follow-up program in HIV.

Tab. 1 Spectrum of microorganisms colonizing the respiratory tract in Kyrgyz versus Cambodian children with HIV on HAART

Species	Kyrgyz children	Khmer children	P
<i>Neisseria catarrhalis</i>	20.48%	51%	p<0,01
<i>Moraxella catarrhalis</i> AMP-R	7.23%	6.2%	NS
<i>Streptococcus viridans</i> PEN-R	20.48%	5.1%	p<0,01
<i>Streptococcus pneumoniae</i> PEN-R	9.64%	5.1%	NS
MSSA	10.84%	10.1%	NS
MRSA	2.41%	45.2%	p<0,001
CoNS <i>Staphylococcus</i> spp	8.43%	10.1%	NS
<i>Candida albicans</i> FLU-R	15.66%	10.1%	NS
Others*	4.82%	4.0%	NS

Notes:

MSSA – methicillin-susceptible *S. aureus*

MRSA – methicillin-resistant *S. aureus*

Other*:

CoNS - coagulase-negative staphylococci, **Escherichia coli* (1), *Proteus mirabilis* (1), *Pseudomonas aeruginosa* (1), *Enterococcus faecalis* (1)

Results and Discussion

In 51 HIV positive children we found out *Neisseria catarrhalis* (20.48%), *Streptococcus viridans* (20.48%) and *Candida albicans* (15.66%) being the most frequent microorganisms. Interestingly, prevalence of staphylococci was not very high (18-21.69%), and surprisingly, only 2 cases (2.41%) of MRSA were noticed ($P < 0,01 - 0,001$) Tab.1.

Also, resistance rate among bacteria was really low, with clindamycin resistance acting as the most prevalent (5.6% of bacteria isolates), followed by ampicillin and erythromycin (4.9% and 2.8%, respectively). Resistance to 5-fluorocytosine was noted in one *C. albicans* isolate, with the rest of candida isolates being fully susceptible to all antifungals tested. Co-infection with 2 or 3 microorganisms was identified in 20 patients (39.22%). In Cambodian children, isolation of MRSA was significantly higher ($P < 0.01 - 0,001$) (Tab. 1) (6-7).

Conclusion

Resistance rate among bacterial isolates from HIV positive Kyrgyz children is, fortunately, very low, even to ampicillin, which was often used in their previous therapy. These results are very interesting, especially when compared to our previous studies in Cambodian children after 3 years of HAART, in which resistance among gram-positives was definitely higher

(50-59%). Thus, this group of children deserves more research to be done.

References

1. PRESTILEO T, DI LORENZE F, Corrao S: *Infectious Diseases among African irregular migrants in Italy. Just an individual problem?* Clin. Soc. Work 2015, 5, 45
2. SAGAT T: Sepsis in pediatrics, Lek obz., 2015, 2, 51-52
3. ESCOBIO FAVILA, ECHEVARRIA JOTA, RUBAKI SILVIA, VINICZAI VIRAG: *Health assistance of displaced people along the Balkan Route*, Lancet 2015, 386, Dec. 19, 2475
4. WICZMANDYOVA D, TKACOVA L, MURGOVA M: Proceedings Slov. Med. Univ: The Socio Economic aspect of Migrations, ISBN 978-80-89352-47-0, pp.62-70
5. WICZMANDYOVA D, MURGOVA A, *The life of diabetics, life with diabetes*, Book.Clear Michalovce ISBN 978-80-9711629255 .2012, pp 67
6. SILHAROVA B, SUVADA J, FRANEKOVA M, NOGE A, MIKOLASOVA G: *Malaria in hyperendemic region*, Neuroendocrinology Letters. 34, 2013, s1 38-43
7. SUN YS, ZHAO XY, ZHANG BK, JIANG JF, LU HJ, CAO YX, WU GZ, QIAN J, SUN Y, ZENG YJ: Practices and thinking of laboratory detection in the aid to West Africa to fight against Ebola. Bratislava Medical Journal Vol.117, No.5, p.254-257, 2016. doi:10.4149/BLL_2016_049.

Six month follow up in communicable versus non-communicable diseases in an Iraqi refugee camp

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Key words:

Diabetes, Hypertension, Respiratory tract infections.

Key message:

Despite overcrowding conditions, Iraqi refugees do not suffer from communicable diseases in comparison to non-communicable illnesses.

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Abstract:

Introduction: Massive internal displacement of Iraqi civilian in Autonomous Kurdistan led to humanitarian catastrophe. The aim of the study is to assess comparison of communicable to non-communicable diseases among the internally displaced in Autonomous Kurdistan.

Patients and Methods: In an open cohort two arm study, children vs adults and communicable vs non-communicable diseases, the occurrence of infectious and non-infectious diseases were compared during the first 6 months of 2016. Within the selected population of refugees

from the Mosul area of Northern Iraq and a timeframe of 6 months we performed 2,844 health consultations.

Results: 2,844 patients have been seen from a 9,000 size camp in the 6 months from January to June 2016: 212 patients were children; 1,632 adults. Acute Respiratory Infections were the most frequently diagnosed infection diseases, but represented only a minority among visits (325 of 2,844 cases, 12.4%). The rest, 87.6%, were war-conflict related diseases such as hypertension, depression, diabetes.

Conclusion: Non-infectious diseases prevalent among Iraqi refugees include asthma, diabetes, hypertension and reactive psychiatric disorders.

Introduction

After Mosul had been occupied by DAESH - forces of the self-declared Islamic State (IS) - about 1 million of the 3 million population was internally displaced (IDP) into UNHCR camps in the northwest of the Autonomous Republic of Kurdistan. One of the largest and oldest is the IB-2 Camp with capacity for 10,000 inhabitants where approximately 9,000 IDPs are still residing (1-5). The aim of this communication is to compare underlying diseases in both groups of IDP refugees in 2016.

Patients and Methods

In an open cohort two arm study: children vs adults and communicable vs non-communicable diseases, the occurrence of infectious and non-infectious diseases were compared during the first 6 months of 2016. We performed 2,844 health consultations within the selected population of refugees from the Mosul area of Northern Iraq within the 6 months timeframe.

Results

In the 6 months from January to June 2016, 2,844 patients from the 9,000 have been seen; 212 patients were children and 1,632 adults. Acute Respiratory Infections were the most frequently diagnosed infection diseases but represented only a minority among visits (325 of 2844 cases, 12.4%).

The rest (87.6%) were war-conflict related diseases such as hypertension, depression, diabetes.

Patients and Methods

Six months daily follow-up was performed with the population of Iraqi refugees from Mosul in an open cohort study in the single internally displaced type camp in Autonomous Kurdistan.

Results and Discussion

In the 6 months from January to June 2016, 2,844 patients from the 9,000 have been seen; 212 were children and 1,632 adults. Acute Respiratory Infections were the most frequently diagnosed infectious diseases, but represented only a minority of 325 from 2,844 cases (12.4%). The rest (87.6%) were war-conflict related diseases such as hypertension, depression, diabetes.

As seen from **Table 1**, infectious diseases (all but 7 of 325) were mostly respiratory infections (98%). This is a sign of a good hygienic standard and high public health level in the camp compared to the displacement after genocide in Rwanda in 1945 where a cholera outbreak had been reported (1-5); or after disaster relief on Haiti in 2010 where more than 300,000 cases of cholera have been observed among IDP after the earthquake (6). Also, other types of disease such as scabies were quite rare compared

to the “migrating” refugees on the Balkan Route (7). Suspected cases of diphtheria were not confirmed. Only 4 cases of Acute and Bloody Diarrhea among 2,844 visits have been observed (0.1%). Non-communicable diseases were highly prevalent (88%).

Tab.1 Clinic of Bl. Zdenka Schelling, Erbil – spectrum of patients

	No of cases <5Y		No of cases >=5Y	
	Male	Female	Male	Female
Respiratory Diseases				
1.Acute (upper) respiratory infection	54	46	105	120
2.Acute (lower) respiratory inf. (suspected Pneumonia)	3	2	8	1
Water Borne Diseases				
1.Acute Diarrhea	1	0	1	1
2.Bloody Diarrhea	1	0	0	0
3. Acute Watery Diarrhea	0	0	0	0
4.Acute Jaundice Syndrome	0	0	0	0
Vaccine Preventable Diseases				
1.Acute Flaccid Paralysis	0	0	0	0
2.Suspected Measles	0	0	0	0
3.Suspected Meningitis	0	0	1	1
4.Suspected Diphtheria	0	0	0	1
5.Suspected Pertussis	0	0	0	0
6.Suspected Neonatal Tetanus	0	0	0	0
Other Communicable Diseases				
1.Unexplained Fever	0	0	0	0
2.Suspected Leishmaniosis	0	0	0	0
3.Suspected Hemorrhagic fever	0	0	0	0
4.Skin Infections (Scabies)	0	0	2	1
5.Animal Bites	0	0	0	1
6.Acute Malnutrition	0	0	0	0
7.Other unusual communicable Diseases	0	0	0	1
8.Total number of all consultations	1	3	4	17

	Male No of cases <5Y	Female No of cases <5Y	Male No of cases <5Y	Female No of cases <5Y	Total numb.
Hypertension: Diagnose	0	0	45	77	122
Hypertension: Check up	4	0	340	414	758
Diabetes: Diagnose	0	0	45	77	122
Diabetes: Check up	3	0	144	218	365
Total # of all consultations	107	105	1,062	1,570	2,844

Conclusions

Massive internal displacement of Iraqi civilians into Autonomous Kurdistan led to humanitarian catastrophe. The aim of this study was to provide a comparison of communicable and non-communicable diseases among internally displaced people in Autonomous Kurdistan. Non-communicable diseases have high prevalence among populations of Iraqis from Mosul to Irbil.

References

1. PRESTILEO T, Di LORENZE F, Corrao S: *Infectious Diseases among African irregular migrants in Italy. Just an individual problem?* Clin. Soc. Work 2015, 5, 45
2. WICZMANDYOVA D., MURGOVA A., *The life of diabetics, life with diabete,* Book.Clear. Michalovce ISBN 978-80-9711629255 .2012, pp 67
3. ESCOBIO F, ECHEVARRIA J, RUBAKI S, VINICZAI V: *Health assistance of displaced people along the Balkan Route,* Lancet 2015, 386, Dec.19, 2475
4. WICZMANDYOVA D, TKACOVA, L, MURGOVA, M: *Proceedings Slov. Med. Univ.: The Socio Economic aspect of Migrations,* ISBN 978-80-89352-47-0, pp.62-70
5. KRČMERY V, KALAVSKY E: *ATB and ATP resistance in ATB free pneumonia* Neuroendocrinology Letters 2007, 29
6. SILHAROVA B, SUVADA J, FRANEKOVA M, NOGE A, MIKOLASOVA G: *Malaria in hyperendemic region,* Neuroendocrinology Letters. 34, 2013, s1 38-43

Situation analysis in 3,503 refugees from Mosul to Dohuk and Healthcare in an UNHCR refugee camp in Dohuk

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Refugees, Health.

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Abstract:

Introduction: The aim of this situation analysis was to compare two phases, acute and post-acute, of disease epidemiology among refugees in the first 6 months (i) and a second 6 months post-acute (ii) period after displacement to an UNNCR camp within the Slovak Field Clinic. **Patients and Methods:** All together, 3,503 refugees appeared before an humanitarian team at a Mobile Clinic in Dohuk and Sinjar close to the transit border in Northwestern Kurdistan where about 1 million people were displaced after ISIS took over Mosul with its 3 million inhabitants.

Results: In the post-acute period, only 18 cases of diarrhea in four camps is a sign of safe water and high health food standard safety in the designated (UNHCR) camps.

Conclusion: Typical infectious in overcrowded camp populations such gastroenteritis, diarrhea, Hepatitis A, were absent in our group of refugees and migrants.

Introduction

The aim of this situation analysis was to compare two phases, acute and post-acute, of disease epidemiology among refugees in the first 6 months (i) and a second 6 months post-acute (ii) period after displacement to an UNNCR camp within the Slovak Field Clinic.

Patients and Methods

The 3,503 visits appeared before a three person humanitarian team at a Mobile Clinic in Dohuk and Sinjar close to a transit border in Northwestern Kurdistan. There are about 1 million people displaced after ISIS took over of Mosul with its 3 million inhabitants. The spectrum of disease was compared in acute and post-acute periods with a **chi-square**-test (EpiInfo, CDC) in a univariate analysis.

Results and Discussion

In the post-acute period, that only 18 cases of diarrhea were found in four designated UNHCR camps in Sinjar is a sign of safe weather and food safety and high public health standards in the camps. Pneumonia (40 vs. 32 cases $P < 0,07$) was more commonly represented, less than 5% in both periods; as well as upper RTI despite seasonal weather (242 vs. 110 cases). This difference was significant ($P < 0,01$) showing surprisingly more RTI in winter (post-acute) versus the autumn (acute) period. From other infectious diseases only scabies was represented in several cases in both periods. Of interest was that vaccination status for all patients was complete and well documented. Therefore, after the first case of diphtheria only a surveillance alert was given; in the second period (2 of 1,798 vs. 1 of 1,705, $P = NS$) with no severe emergency clinical course, no health alert (8-10) was necessary to declare.

Conclusions

Due to good sanitary infrastructure supply and safe water (i) and food safety (ii), diarrheal diseases are surprisingly sporadic. The majority of visits were due to upper respiratory tract infections. Scabies from ectoparasitosis, was the commonest in this group of displaced refugees in North Kurdistan.

References

1. ARASON VA, KRISTINSSON KG, SIGURDSSON JA, STEFANSDOTTIR G, MOLSTAD S, GUDMUNDSSON S: *Do antimicrobials increase the carriage rate of penicillin resistant pneumococci in children? Cross sectional prevalence study.* In BMJ. 1996, August 17, 313 (7054): 387-391
2. HUOVINEN P, MANTTYJARVI R, TOIVANEN P: *Trimethoprim resistance in hospitals.* In Br Med J (Clin Res Ed). 1982 Mar 13; 284 (6318): 782-784
3. SEPPALA H, KLAUKKA T, VUOPIO-VARKILA J, MUOTIALA A, HELENIUS H, LAGER K, HUOVINEN P: 1997 *The effect of changes in the consumption of macrolide antibiotics on erythromycin resistance in group A streptococci in Finland.* Finish Study Group for Antimicrobial Resistance. NEJ Med. Aug 14; 337(7):441-446
4. KRCMERY V, KALAVSKY E 2007 *Antibiotic and antifungal resistance in antibiotic "free" environment?* Neuroendocrinology Letters Nov; 28, Suppl 3:33-4
5. GARAU J, NICOLAU DP, WULLT B, BASSETTI M: *Antibiotic stewardship challenges in the management of community acquired infectious J Glob. Antimicrob Resist* 2, Issue 4, 2014 245-253
6. WICZMANDYOVA D., MURGOVA A, *The life of diabetics, life with diabetes,* Book. Clear Michalovce ISBN 978-80-9711629255 2012, pp 67
7. WICZMANDYOVA D, TKACOVA L, MURGOVA M: Proceedings Slov. Med.

- Univ.: *The Socio Economic aspect of Migrations* ISBN 978-80-89352-47-0, pp.62-70
8. SAGAT T: *Pediatric sepsis* Lekarsky obzor 64, 2015, 2, 51-52
 9. SUN YS, ZHAO XY, ZHANG BK, JIANG JF, LU HJ, CAO YX, WU GZ, QIAN J, SUN Y, ZENG YJ: *Practices and thinking of laboratory detection in the aid to West Africa to fight against Ebola*. Bratislava Medical Journal Vol.117, No.5, p.254-257, 2016. doi:10.4149/BLL_2016_049.
 10. B. SILHAROVA, J. SUVADA, M. FRANEKOVA, A. NOGE, G. MIKOLASOVA,: *Malaria in hyperendemic region*, Neuroendocrinology Letters 34, 2013, s1 38-43

Decreasing occurrence of bacterial STD after introduction of voluntary counseling and testing HIV-program in Eldoret and Naivasha in Kenya in 1999-2013

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Abstract:

Introduction: HIV with Tuberculosis represent “deadly” synergy and HIV with STD “suffering”: Synergy in areas of SS Asia with higher AIDS/HIV prevalence.

Patients and Methods: The aim of this research was to assess the impact of the community based integrated health program focused on HIV/AIDS and tuberculosis (TB) on the occurrence of bacterial STD in the rural community of North Eldoret as well as in the area of Lake Naivasha in Kenya.

Results: Both areas home HIV prevalence of around 6%. A dramatic decrease of HIV was correlated with sustained decrease of bacterial STD's (mainly syphilis and gonorrhea).

Conclusion: An integrated program of HIV/TB (STD) should be supported in the community with higher HIV prevalence.

Introduction

Incidence of bacterial sexually transmitted diseases (STD) correlates with HIV as well with Hepatitis B and C and introduction of an integrated community program usually impacts multiple diseases. The aim of this research was to assess the impact of a community based integrated health program focused on HIV/AIDS and tuberculosis (TB) on the occurrence of bacterial STD in a rural community in North Eldoret as well as in the area of Lake Naivasha in Kenya, both areas with HIV prevalence of around 6%.

Patients and Method

Among all outpatient department (OPD) visits during last 15 years (1999-2013) in both clinics serving about 50,00 people per year, incidence of STD and HIV in infections cases was assessed and correlated. An HIV VCT program has been established in 2008 as a VCT Center next to the Clinic, with one VCT Counselor and one Trained Nurse. All the VCT/HIV Program and all OPD visits for STD were recorded monthly.

Results

Among 42,711 OPD visits in last 4 years, STD was diagnosed in 1,446 patients (3.39%) and HIV in 462 patients (1.08%). However, when the Clinic started its work in 1999, HIV prevalence in males was 8.6% and in females 11.9%. A dramatic decrease of HIV was correlated with sustained decrease of bacterial STD's (mainly syphilis and gonorrhea). While in 2009, 505 cases of bacterial STD and 110 new cases of HIV were detected, in 2010; 421 STD's were diagnosed; 176 in 2011; 201 in 2012; 148 in 2013; followed by a decrease of HIV from 110 in 2009 to 53 in 2013. Unfortunately, while the proportion of adults with HIV and STD was decreasing in 1999-2013 by more than 3-fold, pediatric

STD in children <5 years increased from 1% in 1999 to 3% and 6% in 2010 and in 2013, respectively.

Conclusion

The integrated HIV/STD community program led to a 3.3 fold decrease of STD and a 2.1 fold decrease of HIV prevalence in the rural community of Eldoret, after 15 years of the introduction of VCT. Moreover, the increasing prevalence of STD in children 5 years of age is of great concern. A combination and integration of HIV programs is one of the priorities of UN/WHO, mainly in Sub-Saharan Africa, Central and South-East Asia. A Kenyan example from 1999-2013 shows the efficacy of centered and integrated preventive and therapeutic programs for adults by improving their adherence to treatment.

References

1. JANKECHOVA M: (2007) *The function of nursing in prevention of Lung Tuberculosis* Proceedings Trnava, Typi Tyrnaviensis, pp 355, ISBN 978-80-870-52-8
2. KHASNIS AA, Nettleman MD: (2005) *Global Warming and Infectious Disease*. Archives of Medical Research, Volume 36, Issue 6, 689–696
3. MANZARDO C, Trevigno B, Gómez I, Prat J, Cabezos J *et al*: (2008) *Communicable diseases in the immigrant population attended to in a tropical medicine unit: Epidemiological aspects and public health issue*. Travel Medicine and Infectious Disease, Vol. 6, Issue 1, Pages 4-11
4. WICZMANDYOVA, D, TKACOVA, L, MURGOVA, M: (2012) Proceedings Slov. Med. Univ.: *The Socio Economic aspect of Migrations* ISBN 978-80-89352-47-0, pp 62-70
5. WICZMANDYOVA D, MURGOVA A., *The life of diabetics, life with diabetes* Book.Clear Michalovce ISBN 978-80-9711629255 .2012, pp 67

The Most Common Diseases among Syrian and Palestinian Refugees to Lebanon: Acute and Chronic Stress Related Diseases are Prevalent

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Refugees, Vulnerable populations, Infectious diseases.

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Abstract:

The authors share observations on a cohort of two groups of refugees and show differences between acute and chronic stress and infectious diseases among three generations of Palestinians (1st Group) compared with Syrian, Iraqi and Afghanistan (2nd Group) refugees migrating to Lebanon. We highlight acute risk factors for these pathologies among different groups of migrants, as well.

Lifestyle factors, together with lack of public health services, preventive medicine and access to free healthcare predispose some to specific diseases such as diabetes and hypertension. Hereditary factors are sometimes important, too, as in sickle cell disease, thalassemia and glucose-6-phosphate dehydrogenase deficiency. A minority of Outpatients presented malnutrition, intestinal parasites (*Enterobius*, *Trichuris*, *Strongyloides* and *Ascaris*), filariasis, leishmaniasis, hepatitis A, B and C, tuberculosis, low immunization rate, typhoid fever, yellow fever, malaria, trachoma, syphilis, dengue fever, HIV infection, diarrheal diseases, leprosy, and other communicable diseases which represent less than 30% of all outpatient visits.

Syrian and Palestinian immigrants and refugees have arrived to Lebanon from diverse social, economic, educational, cultural and religious backgrounds for a variety of reasons: to seek work, education, economic advantage or to flee war, political upheaval or persecution or join families from which they have been separated. Many of them have arrived with inadequate resources and suffer social exclusion and inequality of healthcare access. The acute phase following immigration, particularly from the war zones is the time when health can be neglected. They come from healthcare systems that differ from traditional Western medicine, often may involve traditional remedies and health prevention is not part of daily life due to numerous reasons among immigrating families. Stress related disorders are more prevalent than communicable diseases.

Conflict of interest:

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Introduction

Syrian and Palestinian immigrants and refugees have arrived to Lebanon from diverse social, economic, educational, cultural and religious backgrounds for a variety of reasons: to seek work, education, economic advantage or to flee war, political upheaval or persecution or to join families from whom they have been separated. Many of them have arrived with inadequate resources and suffer social exclusion and inequality of healthcare access (1-2). The acute phase following immigration, particularly from the war zones is the time when health can be neglected. Migrants come from healthcare systems that differ from traditional Western medicine, often may involve traditional remedies and health prevention is not part of daily life due to numerous reasons among immigrating families. Stress related disorders such as post-traumatic stress disorders (PTSD) are prevalent in contrast to communicable diseases: 2-3 to 1 (3-4).

Patients and Methods

The St. Charles Foucauld Clinic has two Departments (OPD) and a mobile team visiting families of refugees displaced in the urban area of North Bein or reside at the UNHCR Dbayeh Camp. The population of this camp is about 10,000 and is composed of three generations of Palestinian refugees (50-60%) plus new refugees from Iraq (2012) and Syria (2014-2017). Two doctors and two nurses and full local staff (Lab Technicians, Pharmacist, etc.) offer an OPD 6 x week.

Results and Discussion

As social determinants of health patients visiting our St. Charles Foucauld OPD in the UNHCR Camp presented acute phase hypertension, coronary disease, diabetes, depression, gastrointestinal problems (e.g. lactose intolerance, non-organic abdominal

pain), carcinomas of the cervix, breast, colon and mouth. They also suffered from vitamin D deficiency and such social pathologies as alcoholism and substance abuse.

The second phase, *transition*, typically takes at least 5 to 8 years, with acculturation and modification of social norms, attitudes, values, behaviors and diet; bringing changes not least in the use of health-care services even if in similar ethnic regions as the Near East and Middle East. Most youth and young adults become well integrated into their communities as they adapt to the social environment in Lebanon. But, there is still remaining daily or occasional stress from family (e.g. social insecurity, no money to pay for admission into the hospital, or option to diagnose and then to treat serious diagnoses among family members as cancer, failure of the kidneys, inherited diseases or mental diseases).

The third phase, *10 or more years after arrival*, is typified by the resettled refugees presenting a variety of chronic conditions, seen at least partly as a consequence of resettlement; but in a multicultural society many have acculturated while others continue to live and often work in their own communities. In our work, we share observations from a 5 years treated cohort of refugees and we show differences between acute and chronic stress, and infectious diseases among immigrants from Palestine and Syria to Lebanon; and we highlight risk factors for these conditions among different age groups, as well.

Conclusions

PTSD and other stress related disorders are common in migrant and refugee population and aggravate such chronic conditions as asthma, cardiovascular diseases, diabetes, psychological and psychiatric disorders.

Despite the fact that the majority of refugees in Lebanon originated from Syria, Iraq and Afghanistan, all war zones, infectious diseases are rare. Chronic diseases and conditions worsened by stress, hypertension, coronary heart disease, diabetes and asthma, should be screened as well as infectious diseases.

References

1. PRESTILEO T, Di LORENZE F, Corrao S: (2015) *Infectious Diseases among African irregular migrants in Italy. Just an individual problem?* Clin.Soc.Work, 5, 45
2. ESCOBIO FA, ECHEVARRIA J, RUBAKI S, VINICZAI V (2015) *Health assistance of displaced people along the Balkan Route*, The Lancet, 386, Dec.19, 2475
3. WICZMANDYOVA D, TKACOVA, L, MURGOVA, M: *Proceedings Slovak Med. Univ.: The Socio Economic Aspect of Migrations*, ISBN 978-80-89352-47-0, pp.62-70
4. DUDOVA Z *et al.* (2016) *Six month follow-up in communicable versus non-communicable diseases in an Iraqi refugee camp*, Clinical Social Work and Health Intervention Vol. 7 No. 3

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