HEALTH REGULATIONS FOR AIR TRAVEL (III)

BY

R. H. BARRETT, M.R.C.S., D.P.H., D.T.M.&H.

Medical Officer, Ministry of Health

The attention of the travelling public and of practitioners has often been drawn to the number of inoculations and vaccinations that are obligatory on the intending traveller, particularly if he intends proceeding abroad by air. During the period since 1946 the position described in the first article in this series (*British Medical Journal*, 1947, 2, 741) has become more stable, as was indicated by Kyle in the table appended to the second article (*British Medical Journal*, 1948, 2, 1115). This increase in stability has occurred despite the setback caused by the cholera epidemic in Egypt in 1947, an event which precipitated certain health authorities into adopting quarantine measures that had not been invoked since the Middle Ages. The closing of frontiers and the threat of the use of firearms to prevent the unauthorized entry of persons from an infected or supposedly infected area were examples of a fashion in quarantine which might properly have been left in the textbooks of medical history. Nevertheless, the international outlook as regards quarantine has steadily improved, with a corresponding reduction in the delays and frustrations.

It may therefore be of interest to practitioners and others to know that this particular aspect of international co-operation is being actively pursued by the World Health Organization, which has recently taken over the duties previously carried out in this field by the Office International d'Hygiène Publique in Paris. In October, 1948, an Expert Committee on International Epidemiology and Quarantine met in Geneva and considered amongst other matters a revision of the International Maritime and Aerial Sanitary Conventions, which are to be replaced in the future by WHO Sanitary Regulations. It was very encouraging to note the more liberal attitude adopted by the committee towards quarantine restrictions in the light of the advances made by modern methods in disease control.

In the proposed "principles" on which the WHO Regulations for air travel will be based the following recommendations were made; they are of particular interest:

1. *Plague and Typhus Inoculations.*—These inoculations will not be required of travellers by the new regulations. It was considered by the committee that the use of new insecticides and rodenticides now available should be the most effective method of dealing with outbreaks of these diseases.

2. *Cholera Inoculation.*—This inoculation will not ordinarily be required of travellers; but it will be permissible for individual Governments to require it of passengers coming from local areas infected with cholera.

3. *Transit Passengers.*—Air passengers in transit through foreign airports will not be subjected to any sanitary measures in force for that locality—e.g., compulsory inoculations or vaccinations—provided that they are not suffering from an infectious disease and that they do not leave the precincts of the airport. A passenger will not be considered to have left the airport if he is conveyed to another airport in the same vicinity under the supervision of the health authority.

4. *Immunization of Travellers.*—The committee's views on the subject of immunization of travellers as a quarantine measure are worth quoting at length:

"The committee noted that there had developed since the last war a widespread tendency on the part of health administrations to require from travellers certificates of immunization, irrespective of the value of such immunizations for the protection of the countries reached by the travellers or for that of the travellers themselves.

"The committee was aware of the many disadvantages inherent in the compulsory production of immunization certificates, and considered that the serious obstruction to free and rapid travel caused by such requirement was out of all proportion to the protection likely to be afforded to the country of arrival."

5. *The Personal Declaration of Health.*—This document was compulsory for air travellers in the 1944 Sanitary Convention for Aerial

Navigation, but its use under the WHO Regulations will be optional at the discretion of individual Governments.

Summary

In the future, therefore, it seems that the statutory immunizations likely to be required of travellers, apart from those required for personal protection—e.g., T.A.B.—will be confined to vaccination against smallpox and inoculation against yellow fever, with anti-cholera inoculation as an occasional measure. Practitioners with practical experience of these diseases in epidemic form will probably not quarrel with this decision. But the traveller will no doubt impatiently await the day when world epidemiological conditions will render even these measures unnecessary.

The Expert Committee reflected this feeling in the first of the "principles" upon which the new regulations will be based when it was agreed that "WHO Regulations would be needed until the true object of international epidemic control—the eradication of the pestilential diseases—had been achieved."

INTERNATIONAL CONGRESS OF OTOLARYNGOLOGY EDINBURGH VISIT

A discussion on "Orogenous Thrombophlebitis and its Complications" was held in conjunction with the Scottish Otological and Laryngological Society in the Department of Surgery, University of Edinburgh, on Monday, July 25. Dr. G. Ewart Martin, president of the Scottish society, was in the chair.

In the absence through illness of Professor Norman M. Dott (Edinburgh), who was to have led the discussion, the opening paper was delivered by Dr. BERGER THOMAS (Edinburgh). Dr. Thomas dealt with the complications of thrombophlebitis which might be met in cases exhibiting a resistant strain of organism. He first described aseptic thrombosis of the lateral sinus, which may produce a subacute external hydrocephalus (the post-otitic hydrocephalus of Symonds). This could be demonstrated by ventriculograms. Treatment consisted in the intravenous administration of hypertonic saline solution and the control of cerebrospinal fluid pressure by a lumbar puncture. Where no improvement occurred a subtemporal decompression, with a simple stellate opening in the dura, was advocated.

Aseptic thrombosis of the cerebral branches of the lateral sinus was often silent in onset, the patient first complaining of loss of vision or seizures due to cerebral damage following thrombosis of the veins. Ventriculograms showed localized cerebral involvement with ventricular shift and displacement of the third ventricle. In these cases antibiotics were given, and the cerebrospinal pressure controlled as already described. A bone-flap decompression might be required.

In connexion with the septic complications of thrombophlebitis of the lateral sinus, Dr. Thomas referred to Gradenigo's syndrome, which he thought was seen less commonly since the introduction of antibiotics, and which he regarded not as an apical petrositis from direct spread of the infection but as a thrombophlebitis of the petrosal sinus. Subdural empyema, on the other hand, was more commonly encountered now, particularly after frontal sinusitis. Cerebral and cerebellar abscesses were now considered to be due to a thrombophlebitic process rather than a direct spread of infection. Dr. Thomas showed that tension within the abscess interfered with the penetration of penicillin. When the abscess was drained surgically, penicillin could then be recovered from the pus.

Dr. A. BROWNIE SMITH (Edinburgh) contrasted his experiences of lateral sinus thrombosis before and after the introduction of antibiotics. Although diagnosis was often easy before the advent of penicillin, many cases presented extreme difficulty, and complications were frequent. Since penicillin became available the difficulty of diagnosis had increased but the serious consequences of thrombosis had diminished. Of the 29 cases of lateral sinus thrombophlebitis in his series, 22 occurred before antibiotics were introduced, and of these 14 were complications of acute otitis media. There were seven deaths (32%) in this series. One was due to the anaesthetic, and six occurred from undue delay in operating, either because the case was referred too late or because the condition was not