Fever in the returning traveller
Triage and initial assessment

1 Triage
All febrile travellers should be assessed for evidence of sepsis

qSOFA score
2+ of the following indicates severe infection:
- Glasgow Coma Scale < 15
- Respiratory rate > 22
- Systolic blood pressure < 100

Follow local sepsis pathway
Consider:
- Empirical therapy
- Referral to intensive treatment unit (ITU)

Immune status
Use a lower threshold for admission in those with compromised immune status, as infection can present atypically in this group

May be compromised by:
- Malignancy
- Transplant
- Age
- HIV status
- Diabetes
- Immunosuppressive drugs (including steroids)

2 Isolation
Contact precautions are often required until a diagnosis is confirmed and treatment commenced

Clinical presentation
Are any of the following present?
- Rash
- Diarrhoea
- Respiratory symptoms
- Haemorrhage
- Gastrointestinal or respiratory secretions

Yes →

No → **Isolation not required**

Isolate patient according to risk

🖐 Contact
- Single room or patient cohorting
- Standard contact precautions: Hand hygiene · Gloves · Aprons

💧 Droplet
- Single room or patient cohorting
- Surgical face mask

Airborne
- Negative pressure single room
- FFP3 respirator
- Enhanced precautions for aerosol-generating procedures

✚ Enhanced
- Negative pressure single room
- Fluid repellant surgical face mask
- Eye protection · Plastic apron
- Hand hygiene · Gloves

3 Travel risk assessment

Focused travel history:
- Where did you go?
- What did you do there?
- When did you become unwell?

Is there risk of viral haemorrhagic fever?
Did the patient's symptoms start within 21 days of travel to a VHF endemic country?
Check www.promedmail.org →

Ebola and Marburg virus disease risk
- Caves or mines exposure
- Contact with: Antelopes · Bats · Primates

Lassa fever risk
- Exposure to basic rural conditions

CCHF risk (Crimean-Congo Haemorrhagic fever)
- Tick bite or contact
- Animal slaughter exposure

→
- Enhanced contact precautions
- Inform laboratory services
- Discuss with local infection service
- Notify public health
- Specialist tests required

Is there risk of an emerging severe acute respiratory illness?
Lower respiratory tract infection
- + Symptoms within 14 days of travel to Middle East — MERS
- + Symptoms within 10 days of travel to China ⎫
- + Contact with birds ⎬ influenza
- Exposure to known case

Is there risk of antimicrobial resistance?
Travel to: Asia · Africa · Middle East
Exposures: Healthcare abroad · Antibiotic use during travel

→
- Tailor empirical therapy
- Consider rectal swab screening

Is the patient at risk of malaria?
Patient returns from endemic country
www.map.ox.ac.uk →

- ✔ Urgent diagnostic tests
- ✖ Empirical treatment

Any of these features may suggest severe malaria:

Parasite count:
- >10% = severe
- >2% = at risk

Central nervous system:
- GCS<11 · Prostration · Seizures

Organ dysfunction:
- AKI
- Jaundice
- Pulmonary oedema

Blood markers:
- Acidosis
- Hypoglycaemia
- Anaemia

4 Diagnosis
Once immediate risks have been addressed, take a more detailed travel history to help to identify the infection and guide management

Examination
Consider empirical treatment for specific clinical scenarios

Routine investigations
Blood cultures

Also consider:
- Respiratory virus swab
- Focal microbiology or virology samples
- Imaging · HIV test · Routine blood tests

Specialist investigations
Discuss with local infection specialist, as quality and timing of samples are often crucial

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