The Kenya general practitioner looks at the tourist

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In view of the increasing number of visitors coming to East Africa, especially to Kenya, and the great importance of the fast-developing tourist industry to the country's economy, we analysed in 1968–69 a series of patients seen.

In 1968, the Kenya Faculty of the Royal College of General Practitioners, at that time a small body of only some 14 members and associates, arranged to collect information about the illnesses of those patients who were temporary visitors to the country. As little was known about the morbidity patterns of disease in such people, we sought to discover whether the incidence of locally acquired disease was high and constituted a serious hazard to visitors to this country.

Method

Ten doctors took part in the survey (eight from Nairobi, two from Mombasa), with the casualty officer from the Nairobi (Private) Hospital. All members and associates of the Kenya Faculty were circularised with the pro-formas and one non-member participated.

The patients comprised tourists and businessmen of all races (principally Europeans), on short-term visits from outside East Africa, the vast majority coming from Europe and North America, by air rather than by land or sea.

They were attended only at the two main centres in Kenya, 300 miles apart—Nairobi, the capital (population about 500,000) and Mombasa, the Indian Ocean port (population about 220,000). All the doctors reporting were in private practice as opposed to Government service, and as such would have attended a fair proportion of those visitors requiring medical attention who were staying at the principal hotels in Nairobi and Mombasa.

The doctors represent about 20 per cent of the doctors in these centres likely to have attended such visitors at the time. All doctors participating were in general practice, all Europeans, with no special medical interests; two were women and may have attracted gynaecological symptoms but otherwise there should have been no doctor-selection by patients for specific complaints.

The following details of the patients were recorded: month of arrival, country of origin, age, sex, diagnosis and comments. Almost always only one diagnosis was given.

Returns were made for all such patients which each doctor saw in a prospective survey from July 1968 to October 1969.

The number of patients seen in the survey, compared with the total number of visitors entering the country during this period, is extremely small—a 'visitor' being defined as one staying longer than two days as opposed to a 'transit passenger' who stays less. The figures were obtained from the statistics division of the Ministry of Finance and Economic Planning. Seamen were excluded from the survey.

The Royal College of General Practitioners' classification of disease—amended version 1963—was used.

Results

Details concerning 334 patients (253 Nairobi, 81 Mombasa) were recorded, during the period. 259,636 visitors entered Kenya during the same time. However, in September 1968 for example —43 incidents of illness were reported amongst 13,761 visitors reported as entering the country; with 16,495 departures.

TABLE I
AGE DISTRIBUTION OF PATIENTS

Age group	*Male*	*Female*	*Total*
Under 5	5	1	6
5–14	18	7	25
15–44	72	70	142
45–64	61	58	119
Over 64	15	22	37
Not known	4	1	5
	175	159	334

TABLE II
MAIN MORBIDITY

Upper respiratory infections, including influenza	58	cases
Diarrhoea and vomiting (excluding dysentery)	50	,,
Trauma	38	,,
Urethritis (gonorrhoeal and other)	20	,,
Circulatory system disorders	17	,,
Other genito-urinary disorders	15	,,
Digestive system disorders	14	,,
Bronchitis and pneumonia	13	,,
Malaria	13	,,
Allergic dermatoses	12	,,
Otitis (media and externa)	10	,,
Dysentery (only bacillary reported)	9	,,
Miscellaneous	65	,,
Total	334	,,

Discussion

In this survey, the incidence of illness in visitors would not appear to be very great considering the number present in the country at the time. Medical aid is usually sought when the patient feels sufficiently ill or worried to go to the trouble and expense of visiting or calling a strange doctor in a strange land.

Respiratory disorders

Respiratory disorders had the highest incidence. Many of these were contracted before leaving the home country, or *en route* for Kenya, and medical aid was often sought to clear up a persistent, troublesome infection. Intending travellers should be told of the antisocial behaviour of flying in aeroplanes with an infectious disease and warned of the deleterious effects of changing temperatures and climates on upper respiratory infections, especially in the elderly.

Diarrhoea and vomiting

Diarrhoea and vomiting, as expected, formed another large group. Changes of water and cooking methods, all contribute to these upsets. Unboiled water in outlying areas not on mains supply, 'cold food tables' and unwashed fruit, are potent sources of infection.

The current vogue of prophylactic intestinal antiseptics prescribed for the duration of the traveller's stay abroad is not necessarily effective and may lead to bowel upsets due to interference with the normal intestinal flora. Kaolin or 'Lomotil', to control diarrhoea, sufficed in most cases.

Venereal diseases

Venereal diseases also feature prominently. Visitors should appreciate that there is virtually no control over these diseases in a developing country; contact tracing, for example, is unknown. It is therefore extremely easy to acquire infections of all kinds from casual sex contacts, which will spoil the visit and may lead to great difficulty in successful treatment owing to the emergence of antibiotic-resistant strains of Neisseriae.

Trauma

Trauma, as might be expected, constituted a major source of trouble in this series. The figure may well be lower than expected but this may be because serious injuries are usually taken direct to hospital and do not pass through the general practitioner, unless he is on call for hospital casualty.

Lacerations and contusions formed a major part of this group and many of these tend to become infected. Early wound toilet is important and active immunization against tetanus should always be advised if not already done, before travelling here. Road accidents here are reaching frightening proportions with the advent of good tarmac roads and increasing numbers of road vehicles of all kinds.

Malaria

We had 13 proved cases, two infected in other parts of Africa. Malaria is endemic in most parts of Kenya but is most prevalent at the coast and round Lake Victoria. Drug prophylaxis is therefore most important and should start before arrival in the area and be continued for at least four weeks after departure. Proguanil 100 mg daily or chloroquine 300 mg weekly are the most commonly used drugs. There is no record of whether any of our patients in this series were taking prophylactics.

Allergic dermatoses

Allergic dermatoses were mostly due to insect bites and sunburn.

Ear infections

Otitis externa and media are hazards of constant bathing in the hot humid climate of the coast. Care should be taken in susceptible subjects to dry the ears after swimming and apply spirit drops. Acute otitis media is a contra-indication to air travel, especially in children.

Summary

A survey of cases of illness occurring in visitors to Kenya in 1968–69 is presented.

It is recognised that no epidemiological conclusions can be drawn from this information but an analysis of the illnesses encountered has been used to highlight some of the commoner medical problems that may be encountered here.

We hope that this discussion will be of value to those having to advise intending travellers to this country, and of interest to those who may be called upon to treat them after arrival.

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