Irish immigrants have their problems too

BECAUSE of longstanding free access between both countries, there is an established pattern of Irish emigration to Britain, especially in times of economic depression such as during the great famine of 1845–49, the 1930s, the 1950s and most recently in the mid-1980s. In 1971 1.8% of the population of England and Wales had been born in both parts of Ireland.

While Irish immigrants do not generally share the linguistic, racial and broad cultural disadvantages of other immigrants, they tend to be from the lower social classes and have predictable mortality patterns. The standard mortality ratio of male Irish immigrants to England and Wales between 1970–72 was higher than that of the male population in Ireland and the general population in England and Wales. In contrast, female immigrants had a standardized mortality ratio a little lower than the female population in Ireland and a little higher than the total female population in England and Wales. Mortality in both sexes was highest, relative to Ireland, in conditions with a behavioural background, such as smoking-related cancers, obstructive airways disease, peptic ulcer, cirrhosis, accidents, poisoning and violence, and in tuberculosis as well.

Ease of migration may mean that ill health and economic and social disadvantage, rather than acting as a barrier, may act as a spur to migration. A change from the rural Irish environment to the industrial environment of England, and heavy smoking habits, may explain the higher lung cancer rates among immigrant men. Doctors practising in areas such as London, the Midlands, Liverpool and Glasgow — traditional destinations for Irish immigrants — should be aware of these trends as large-scale Irish immigration is likely to continue.

(C.D.)

Source: Adelstein AM, Marmot MG, Dean G, Bradshaw JS. Comparison of mortality of Irish immigrants in England and Wales with that of Irish and British nationals. *Ir Med J* 1986; **79:** 185-189.

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FILL THIS SPACE

Contributions to the Digest pages are welcome from all readers. These should be from recent papers in research journals which general practitioners might not normally read. Send to: The Editor, Journal of the Royal College of General Practitioners, 8 Queen Street, Edinburgh EH2 1JE. Please quote the full reference to the article (authors, title, journal, year, volume, page range).

INFECTIOUS DISEASES UPDATE

Advice for travellers

The Department of Health and Social Security has in 1988 brought out a new and colourful edition of a travellers guide for health entitled *Before you go.* This pamphlet SA40 replaces the previous SA30 and 35. It is free of charge and can be obtained by telephoning 0800-555777 or in bulk from DHSS Leaflets Unit, PO Box 21, Stanmore HA7 1AY. The information given includes a country by country listing of recommended vaccinations and whether or not malaria is present. Additional comments on immunoglobulin against hepatitis A and on bacille Calmette-Guérin (BCG) are made and advice given on rabies and the acquired immune deficiency syndrome. The advice is concise and therefore is not able to take into account to any great extent the traveller's intended lifestyle — for example, administering cholera vaccine to the businessman staying two nights in a four star hotel in Kuala Lumpa may be considered excessive — but this can be allowed for during consultations. The booklet gives advice on malaria prevention and general measures such as avoiding mosquito bites. It does not go into detail about regional differences in prevalence within a country or describe which prophylactic tablets may be appropriate.

The book updated annually by the World Health Organization, *Vaccine certificate requirements and health advice for international travel* (available through Her Majesty's stationery offices, price Sw fr 14, approximately £8), gives regions within countries where the greatest risk exists and whether or not there is drug resistance. This further information can help avoid the unnecessary use of prophylactic tablets with their occasional side effects and indicate when two drugs taken in combination may be preferred because of resistance problems.

Further information for advising travellers is available in a variety of books: *Travellers health* by Richard Daywood (Oxford University Press, 496 pages, price £6.95) gives a comprehensive look at prevention. *Well away: a health guide for travellers* by E. Walker and G. Williams (British Medical Journal, 56 pages, price £5.00) gives a briefer account for the lay public or the general practitioner needing an occasional source of reference.

Meningococcal infection in Africa

This year has seen a large outbreak of meningococcal septicaemia and meningitis especially in the eastern parts of the 'meningococcal belt' of sub-Saharan Africa. Countries affected included Sudan, Ethiopia and Chad. Several thousands of cases were reported to the World Health Organization with a mortality of approximately 10%. In 1987 this annual epidemic spread across into the Arabian peninsular. A single dose of vaccine which gives protection for about two years against the 'C strain' normally responsible for epidemics can be obtained on a named patient basis from Merieux UK Ltd in single dose or from Smith, Kline and French Ltd in 10 dose vials.

Measles, mumps and rubella vaccine

This combined vaccine will soon be introduced throughout the UK and it should replace monovalent measles vaccine, normally given to children at around 15 months of age. It is hoped that the publicity surrounding its introduction and the advantages of a three-in-one injection will encourage a high uptake which has never been achieved with the measles vaccine alone. The combined vaccine has for some years been used successfully in the USA and rubella vaccine alone should still be offered to girls at secondary school both to cover children who missed out on the vaccine as infants and to ensure good antibody levels as girls reach the childbearing age. As with monovalent measles vaccine, when the combined vaccine is given to infants aged under one year (for example prior to travel to highly measles endemic areas or to children with fibrocystic disease) then a further dose during the second year of life is advisable.

Suggestions for topics to include in future updates are welcomed and should be passed to the contributor, Dr E. Walker, Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB (041-946-7120), from whom further information about the current topics can be obtained.