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ORIGINAL ARTICLE

Imported infectious diseases in tertiary hospitals☆

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Abstract
Introduction: An Imported Diseases Clinic was created in the hospital in 2009. The aim of this study was to assess its contribution in terms of capacity, quality of care and teaching offered.
Patients and methods: A retrospective study was conducted from 2009 to 2011, analyzing: (A) development of knowledge by means of protocols and publications created, and subject taught; (B) capacity and quality of care offered by the analysis of patients seen, the adequacy of the protocols and accessibility.

The patients were classified into 3 groups. Group 1: immigrant patient screening, group 2: patient consultation after tropical or sub-tropical travel, group 3: screening of vertical transmission of imported disease.
Results: Six protocols have been developed and disseminated on the unit website, as well as 5 scientific publications. A total of 316 patients were evaluated: 191 included in group 1 (29 Adopted and 162 Immigrants), 57 in group 2 (94.7% Visiting Friends and Relatives and 81.5% without a pre-travel consultation). They consulted due to, gastrointestinal symptoms (52.6%) and fever (43.8%), with 68 included in group 3 at risk of imported disease by vertical transmission (62 *Trypanosoma cruzi*, 1 Human T Lymphotropic Virus and 5 *Plasmodium* spp.). The overall adherence to the protocols was about 77.1%.
Discussion: Infectious Diseases Units must adapt to the reality of the population and be flexible in its structure. Periodic assessment of the quality of care offered is essential, as well as an evaluation on the need for additional studies.

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PALABRAS CLAVE
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Enfermedades infecciosas de transmisión vertical

Patología infecciosa importada en hospitales terciarios

Resumen
Introducción: En el año 2009 se crea en nuestro centro una Consulta de Patología Importada. El objetivo de este trabajo es conocer su aportación en cuanto a capacidad, calidad asistencial y docencia ofrecida.
Pacientes y métodos: Estudio retrospectivo entre 2009 y 2011 donde se analizan: a) desarrollo del conocimiento mediante la valoración de protocolos y publicaciones realizadas, así como la docencia impartida; y b) capacidad y calidad asistencial ofrecida mediante el análisis de los pacientes atendidos, la adecuación a los protocolos y la accesibilidad a la consulta. Se clasifican los pacientes atendidos en 3 grupos: grupo 1 cribado del paciente inmigrante; grupo 2 consulta tras viaje a zona tropical o subtropical; grupo 3 cribado de enfermedad importada de transmisión vertical.
Resultados: Se han desarrollado y difundido en la web de la unidad 6 protocolos y 5 publicaciones científicas. Se han atendido 316 pacientes: 191 incluidos en el grupo 1 (29 adoptados y 162 inmigrantes); 57 en el grupo 2 (94,7% *Visiting Friends and Relatives* y 81,5% sin consulta previaje), que acudieron principalmente por clínica gastrointestinal (52,6%) y fiebre (43,8%); y 68 en el grupo 3 con riesgo de infección importada de transmisión vertical (62 Trypanosoma cruzi, 1 virus linfotrópico T humano y 5 *Plasmodium* spp.). La adecuación global a los protocolos disponibles fue del 77,1%.
Discusión: Las unidades de patología infecciosa deben adaptarse a la realidad de la población que atienden, siendo flexibles en su estructura. Es imprescindible la valoración periódica de la calidad asistencial ofrecida, así como la valoración en la rentabilidad de los estudios complementarios a realizar.

Introduction and aims

In January 2012 there were over 5 million foreigners resident in Spain, 15.8% of whom were under 16.[1] Like their parents, immigrant children and those born into families who have arrived recently are at greater risk of suffering from imported diseases unfamiliar to healthcare staff, with certain exceptions such as tuberculosis that are also very prevalent in Spain. In addition, the large number of international adoptions, as well as the increase in travel to low-income countries, are conducive to the presence of these diseases in Spain.[2,3] They are diseases contracted in another country and diagnosed in the host country, where they are either absent or of low prevalence, but they can entail high morbidity and mortality. Although some of them will not be transmitted in the same way as in the country of origin, because of differences in climatic and vectorial conditions, others may represent a potential risk to population health.[4–6]

There are various handbooks devoted to the care of immigrant paediatric patients, and protocols for diagnosis, treatment, and screening in cases of risk of vertical transmission or after trips to high-risk countries.[7–12] Use of protocols, teamwork, and continuing education, as well as specialised training for resident physicians should make it possible to detect and treat imported infections promptly and also to optimise resources devoted to the care of these patients.

In response to the increase in consultations on imported diseases in our unit, a specialised clinic was created in 2009 to provide comprehensive treatment for problems affecting immigrant children or children of immigrants with risk factors and internationally adopted children, as well as those arising from travel to high-risk areas. Since it began we have worked on formulating diagnostic and therapeutic guidelines, set out in various consensus protocols.

This article analyses the first years of operation of our clinic, examining the characteristics of the patients treated and their diseases, and also the advantages of a centralised service in terms of quality of care and teaching.

Patients and methods

We conducted a retrospective study analysing the first three years (January 2009 to December 2011) of operation of the Imported Infectious Diseases Clinic in our unit.

Firstly, we analysed the knowledge generated since its establishment, by evaluating newly formulated protocols and clinical practice guidelines and group work with specialists in other areas and with learned societies, as well as the dissemination of that knowledge through meetings, publications and online communication.

Secondly, we analysed the clinical care delivered in terms of its quality and characteristics. The quality of care provided was assessed in respect of its accessibility. For this purpose we evaluated the delay in initial assessment, defined as the time that elapses from referral to visit, as well as the possibility of consultation by telephone. The study describes patient characteristics, reason for and source of referral, and the disease detected. A descriptive analysis was performed by reviewing the medical histories of patients of paediatric age (<18) seen during the study