Training the physician for deployment

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TO THE EDITOR: I wish to congratulate Captain Timothy Humphery for his excellent article, "Training the physician for deployment", recently published in *ADF Health*.[1] I wish to take the opportunity to expand slightly on the section dealing with tropical medicine training. Two programs were specifically mentioned, which were the "six-month course on tropical medicine conducted by the Mahidol University in Thailand" and the "shorter tropical medicine course being offered by James Cook University". Both of these programs lead to the classically named postgraduate Diploma of Tropical Medicine and Hygiene (DTM&H).

A few years ago, there were more than 100 academic programs in tropical medicine and related areas catalogued from around the world in the major directories of training in tropical medicine.[2,3] These programs ranged from short courses to doctoral degrees in tropical medicine. Among these were two Diploma of Tropical Medicine (DTM) courses and five DTM&H courses conducted in Australia, Ireland, Japan, South Africa, Thailand and the United Kingdom. All of these programs are stated to be by coursework, although there may be limited opportunities for clinical work in some programs.

The DTM&H offered at Mahidol University, Bangkok, is a six-month, whole-of-time course, equivalent to one year of full-time study in Australia. This course has traditionally had an emphasis on the scientific basis of tropical medicine, with extensive laboratory work on a range of parasitic, entomological and microbiological specimens.[4] This program articulates to a unique Master of Clinical Tropical Medicine (MCTM) course, a further six-month full-time course, which includes clinical tropical medicine and research experience, as well as some coursework.[4]

The DTM&H offered at James Cook University, Townsville, is a two-semester course of eight subjects, equivalent to one year of full-time study, which can be accelerated by the completion of block courses on campus. This program articulates to a Master of Public Health and Tropical Medicine (MPH&TM), which provides expanded opportunities for DTM&H graduates. Readers may not be aware that the first DTM&H course in Australia was offered in Townsville in 1925–1926 at the then Australian Institute of Tropical Medicine, the first medical research institute established in the country.[5] The heritage building still remains today, now named after the first director of the Institute, Dr Anton Breinl, and preserved by the National Trust.

1. Humphery TJ. Training the physician for deployment. *ADF Health* 2002; 3: 9-12.
2. The Australasian College of Tropical Medicine. International directory of training in tropical medicine 1995-96. Townsville: ACTM Publications, 1995.
3. The American Society of Tropical Medicine and Hygiene. International training programs in tropical medicine and health in the Annual Directory of International Opportunities. *Am J Trop Med Hyg* 1994; 51 Suppl: 23S-29S.
4. Leggat PA. Tour of duty: studying tropical diseases in Thailand. *Med J Aust* 1991; 155: 801-802.
5. Baldwin AH. The first course for the Australian Diploma in Tropical Medicine and Hygiene. *Health* 1926; Nov: 163-165. ❑

The Western Front pilgrimage for World War I veterans, 1993

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TO THE EDITOR: In the previous issue of *ADF Health*, Capps and Killer described the preflight work-up of a group of aged veterans soon to travel to Europe.[1] An altitude chamber was used to assess the physiological response to mild hypoxia expected in aircraft.

As a respiratory physician who has never seen, let alone needed, a barochamber, I am reassured that I have never yet lost a patient *par avion*. I recommend the subject undergo a case-specific assessment, which should include investigating the possibility of undiagnosed obstructive sleep apnoea or central sleep apnoea, as the most dangerous period inflight is during recumbent rapid-eye-movement sleep. Although the elderly spend considerable time asleep during flight, Capps and Killer did not mention sleep apnoea or Cheyne–Stokes breathing.

For the vast majority of travellers, regardless of age, a forced expiratory volume in one second greater than one litre and resting oxygen saturation greater than 90% bodes well for air travel (no need for measurement of arterial blood gases). I have never been let down once by this maxim. For smokers or those with basal crackles, I measure diffusing capacity (CO uptake). This takes five minutes and, with a few added extras, it is possible to work out the five causes of hypoxaemia:

1. Low ambient oxygen tension (eg, low cabin pressure)
2. Hypoventilation (eg, sleep apnoea and too much wine)
3. Ventilation/perfusion mismatch (eg, chronic obstructive airway disease)
4. Diffusion block (eg, emphysema)
5. Shunt (eg, intracardiac and intrapulmonary).