NUFFIELD DEPARTMENT OF PRIMARY CARE HEALTH SCIENCES
RESEARCH & SURVEILLANCE CENTRE

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OXFORD-RCGP RSC DIRECTOR'S MESSAGE

YOUR WEEKLY UPDATE FROM PROF. SIMON DE LUSIGNAN, DIRECTOR OF THE OXFORD-RCGP RSC

The Forgotten Post-Travel Consultation

It's tempting to think that travel medicine ends when a patient returns home. Those in primary care know better. As international travel becomes increasingly common, primary care clinicians are more likely to encounter travel-related illnesses that present weeks, or even months, after a patient has returned. A simple travel history can be key to making the diagnosis.

Persistent diarrhoea lasting more than two weeks should prompt consideration of protozoal infections such as *Giardia, Cryptosporidium,* or *Cyclospora*, rather than repeated empirical antibiotic treatment. Similarly, unexplained fever, eosinophilia, chronic cough, or fatigue in a returning traveller should raise suspicion for infections such as schistosomiasis, strongyloidiasis, tuberculosis, or malaria.

When assessing a patient with unexplained symptoms, remember to ask where they travelled, when they returned, and about any freshwater, food, or insect exposures. If an imported infection is suspected, don't hesitate to seek advice from your local microbiology or infectious diseases team. You can access referral services online.

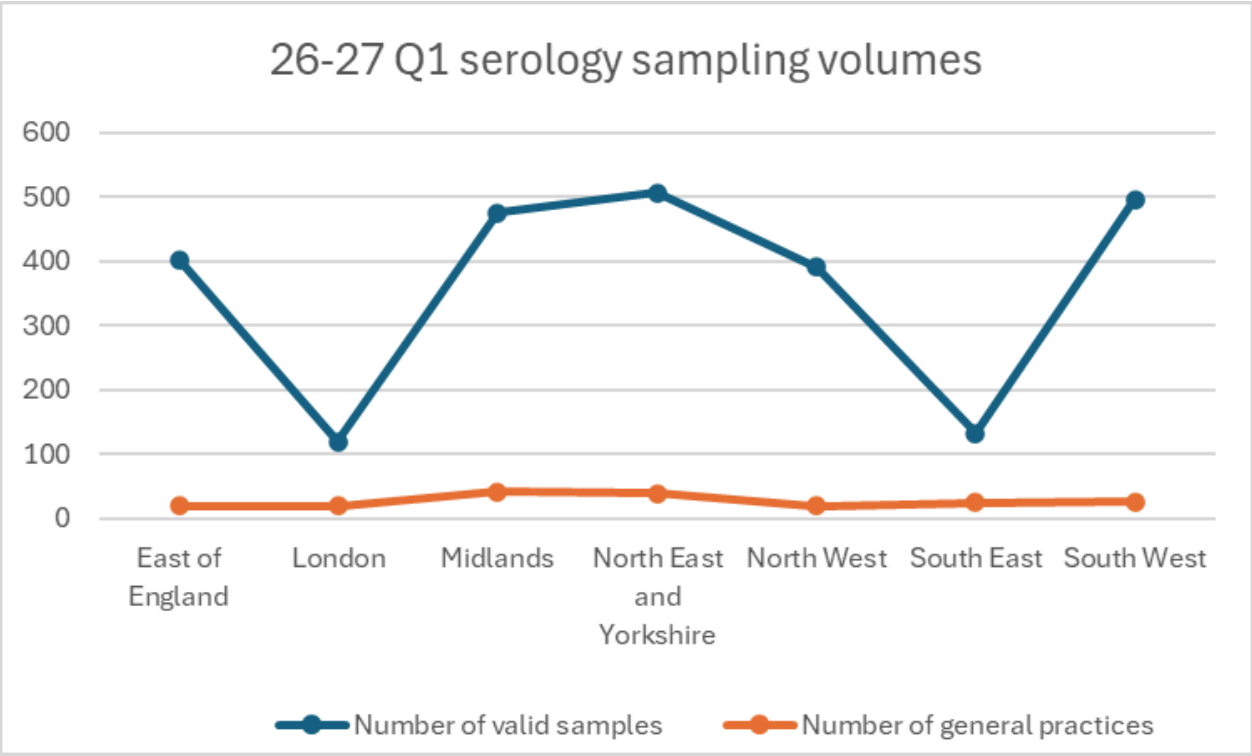
A message from the Practice Liaison Team

Serology Sampling:

Our serology surveillance programme continues throughout the year, with participating practices working towards monthly targets of **1,000 adult samples** (split between **18–64** and **65+ years**) and **500 paediatric samples** (split between **0–8** and **9–17 years**). Looking at the Q1 performance, we have seen significantly fewer samples collected across the **NHS London and South East regions**. Over the coming weeks, we will be contacting practices in these regions to gather feedback, better understand any challenges, and explore how we can support increased sampling, including onboarding new practices where appropriate.

To all of our participating practices, a big **thank you**. Your continued commitment and support are invaluable to the success of our surveillance programme. We are grateful for your ongoing efforts, and it's fantastic to see such strong sampling across most regions. Let's keep those numbers coming!

We also continue to encourage the collection of **paediatric samples**. While collections are beginning to rise, we still need more samples to achieve our monthly target. If your practice carries out blood sampling for patients **under 18 years of age** and has not yet joined our serology surveillance programme, we'd love to hear from you. Please get in touch with the **Practice Liaison team** and we'll be happy to discuss the programme and the sampling pathway that best suits your practice.



Sampling Is Informing

Welcome to the newest segment of our weekly newsletter

Lettuce talk about Cyclospora Cases

This week we've been following the Cyclospora outbreaks in America, which has been linked to consumption of contaminated lettuce, which may be linked to a specific producer in Mexico: Investigation Update: Cyclospora Outbreak, July 2026 | Cyclosporiasis | CDC

It's not an infection commonly seen in the UK, as it occurs in mainly tropical and subtropical climates, but has been implicated in cases of diarrhoea in returning travellers, or ingestion of imported fresh food (with common vectors being raspberries, snow peas, lettuce, basil, coriander and field greens, as well as drinking contaminated water). In the early 2000s, 32 cases were reported per year in England and Wales, and in our database, we have noted this infection occurring only twice in the last couple of years: Cyclospora: clinical and travel guidance - GOV.UK

The pathogen is a parasite which causes flu-like illness followed by more specific gastrointestinal symptoms comprising watery diarrhoea, myalgia, abdominal cramps, wind/bloating, nausea and anorexia. Symptom onset is around 7 days after ingestion, and therefore timing and specific travel history and food diary is important in identifying possible cases. The illness course is mild in the majority of patients, but may be severe if immunocompromised, and these cases may be treated with co-trimoxazole following a positive identification on lab sample.

Cyclospora is a notifiable disease, and the lab should notify UKHSA directly, but it is helpful for contact tracing and triangulation to provide supplementary information from GP practice as well, on receipt of a positive sample, and particularly where institutions may be involved eg schools, nurseries, recreation facilities, restaurants etc. Notifiable diseases process: Laboratory reporting to UKHSA: a guide for diagnostic laboratories

For clinical advice, the local microbiology services are the main port of call, and for returning travellers near a tropical medicine unit, walk-in assessments may be available (eg London School of Tropical Medicine Emergency Walk-In Clinic | The Hospital for Tropical Diseases (HTD) | London). For general advice for patients asking or as clinical reference, the National Travel Health Network and Centre (NaTHNaC) is a fantastic resource, with a useful updated infosheet on Cyclospora for worried travellers: NaTHNaC - Cyclospora and summer travel.