INTRODUCTION

Travellers' diarrhea is the most common illness experienced by travellers from industrialized countries journeying to third humanity countries. Although it is more often than not a self-limiting sickness, and even so mess up three to four days of a holiday or require alteration of holiday plans. Travellers' diarrhea is strikingly common, with an incidence estimated from 20% to over 80%. The occurrence of three or more unformed stools within a 24 hour period or any number of such unformed stools when accompanied by either nausea, vomiting, abdominal cramps, tenesmus (involuntary straining with little or no passage of fecal matter), or fever. Approximately 20 million episodes of diarrhea occur annually in people traveling from industrialized regions to budding countries. Diarrheogenic Escherichia coli, including enterotoxigenic E. coli and enteroraggregative E. coli, are responsible for ~50% of cases. The invasive bacterial pathogens are Shigella, Salmonella, invasive E. coli, and Campylobacter jejuni cause ~10–25% of cases, with the highest frequencies in southern Asia. A study revealed that 46 percent acquired diarrhea conditions are found in developing countries. Traveler’s diarrhea is more common in young children and has a privileged risk of dehydration and serious sickness. The drug of choice for most children with traveler’s diarrhea is Azithromycin. The main complication of traveler’s diarrhea is Dehydration. Bismuth Subsalicylate two tablets QID, which partly protective against travelers’ diarrhea. Treatment with antibiotics is a better alternative. Antibiotic treatment varies depending on the cause of the acute diarrhea. Enhanced defensive and prophylactic measures will be needed until newer antibiotics become available and the sanitation and hygiene in developing countries improve.

Keywords: Antibiotics, diarrhea, prophylaxis, traveler’s diarrhea
bedridden for a day and more than one third have to alter their actions. A study revealed that 46 percent acquired diarrhea conditions are found in budding countries. Destination is the most significant risk factor for developing traveler’s diarrhea. Regions with the highest risks are seen in urbanized countries. Those who are travelers having Immunocompromised as well as lowered gastric acidity are more prone to traveler’s diarrhea. Newly, a genetic defenselessness has been demonstrated. Younger age and adventurous travel increase the risk of developing traveler’s diarrhea, but persons staying at luxury resorts or on cruise ships also are at risk. Food and water contaminated with fecal matter are the main reservoirs for the pathogens that cause traveler’s diarrhea. Hazardous beverages and foods include unpeeled fruits, salads, inadequately cooked meats and seafood, and tap water, unpasteurized dairy products. Intake of foods and any other beverages in restaurants increases the possibility of contracting traveler’s diarrhea and food from street vendors is particularly risky. Cold sauces, salsas, and foods that are cooked and then reheated also are risky.

Common Causes of Traveler’s Diarrhea
The common causes of traveler’s diarrhea were displayed in table 1. In Mexico, Enterotoxigenic E. coli and enteroaggregative E. coli may be accountable for up to 71 percent of cases of traveler’s diarrhea. In contrast, Campylobacter is a leading cause of traveler’s diarrhea in Thailand and also common in Nepal. Cyclospora is endemic in Nepal, Peru, and Haiti. Food poisoning is part of the differential diagnosis of traveler’s diarrhea. Gastroenteritis from preformed toxins (e.g., Staphylococcus aureus, Bacillus cereus) is characterized by a short incubation period and symptoms characteristically subside within one day.

Traveler’s Diarrhea in diverse age groups:
Traveler’s diarrhea is more common in young children and has a privileged risk of dehydration and serious ill health. Children show signs of moderate to bloody diarrhea, severe dehydration, hyperthermia (102°F), or persistent vomiting. Few data exist on the treatment of diarrhea in children. Nursing infants should continue to breastfeed on exact. The infants and grown-up children should be offered their usual food. Azithromycin is the drug of choice for most children with traveler’s diarrhea. Another option is nalidixic acid in a dosage of 55 mg per kg per day divided into four doses, not to exceed 1 g in 24 hours. Loperamide is approved for children less than two years, but in dysentery condition it should not be used. For prophylaxis in children, bismuth subsalicylate should be avoided because of the possible risk of Reye’s syndrome. Pregnant women may be at higher risk of traveler’s diarrhea than nonpregnant women because of lowered gastric acidity and increased gastrointestinal transit time. Quinolones (FDA pregnancy category C) generally are not advised during pregnancy, but azithromycin (category B) is harmless. ORS should be initiated.

Complications
The main complication of traveler’s diarrhea is Dehydration.

Other complications
It includes Guillain-Barré syndrome, Reiter’s syndrome, Clostridium difficile colitis subsequent to antibiotic use, and post infectious irritable bowel. Parasitic causes should be suspected in travelers who return with prolonged diarrhea or who do not respond to these antibiotics. It is reasonable to confer empirical therapy of protozoal infections (e.g., metronidazole 250 mg three times a day for five days or tinidazole in a single 2-g dose for Giardiasis) that traveling to secluded areas for extensive periods.

Treatment
The treatment for traveler’s diarrhea was displayed in table 2. The following foods that are generally considered high-risk:

1) Drinking untreated water (this includes brushing your teeth with it!)
2) Ice cubes in a drink (alcohol does NOT provide protection)
3) Chang (rice beer, usually made with untreated water)
4) Raw vegetables
5) Salad
6) Uncooked fish
7) Uncooked or rare-cooked meat
8) Unpeeled fruit
9) Fresh fruit juice
10) Cheese
11) Ice cream
12) Any kind of street vendor food

**Prophylaxis**
Bismuth Subsalicylate two tablets QID, which partly protective against travellers' diarrhea. Bismuth Subsalicylate is free from side effects but it may transiently cause color tongue and blackish stools, constipation.

**Treatment Issues**
Treatment with antibiotics is a better alternative. Antibiotic treatment varies depending on the cause of the diarrhea. [37]

**CONCLUSION**
Travellers’ diarrhea is the most common illness experienced by travellers and with an incidence estimated from 20% to over 80%. Traveler’s diarrhea is more common in young children and has a privileged risk of dehydration and serious ill health. Azithromycin is the drug of choice for most children with traveler’s diarrhea. The main complication of traveler’s diarrhea is Dehydration. Enhanced defensive and prophylactic measures will be needed until newer antibiotics become available and the sanitation and hygiene in developing countries improve.

<table>
<thead>
<tr>
<th>Table 1: Common Causes of Traveler’s Diarrhea</th>
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<tr>
<td><strong>Bacteria</strong></td>
</tr>
<tr>
<td>Enterotoxigenic: Escherichia coli</td>
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<tr>
<td>Other E. coli types:</td>
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<tr>
<td>Campylobacter</td>
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<tr>
<td>Salmonella</td>
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<td>Shigella</td>
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<td>Aeromonas</td>
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<td>Vibrio</td>
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<th>Table 2: Treatment for Traveler’s Diarrhea</th>
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<tr>
<td><strong>Antibiotic</strong></td>
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<tr>
<td>Ciprofloxacin</td>
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<td>Rifaximin</td>
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<tr>
<td>Azithromycin</td>
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**REFERENCES**
1. Introduction to traveler’s diaper. Available from URL: http://www.high-altitude-medicine.com/diarrhea.html


