Minnesota Department of Health

Suggestions for Medical Screening of Southeast Asian Refugees

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Over 3,000 refugees from Southeast Asia may arrive in Minnesota during the next year, according to some estimates, and over 4,000 are already residing in the state. The Center for Disease Control is responsible for medical screening of refugees while they are still abroad, including examination for tuberculosis, leprosy, venereal disease and mental defects and disorders. Reports from a variety of federal sources indicate, however, that the quality of screening varies and that general medical examination on arrival in a U.S. community will insure treatment of general medical problems, provide for immunization and generally pave the way for future medical care. Although the U.S. Public Health Service is making an effort to improve the screening received in Asia, this is complicated by the fact that refugees are screened at a large number of different sites in Asia.

The overseas screening may improve in the future; meanwhile, the following suggestions are provided for physicians caring for newly arrived Southeast Asian refugees. These comments are intended to supplement the general medical examination for clinically apparent problems such as malnutrition or anemia which are commonly found in this group.

Tuberculosis

This is perhaps the only condition presenting a significant risk to members of the general public in contact with refugees. Twenty-six cases were found among Southeast Asians in Minnesota in 1978. We suggest the following screening procedure if the patient has not previously been screened by a facility of known reliability: (1) Persons through age 21 should be skin tested using needle, syringe and PPD. (2) Persons over 21 should receive both a skin test and a chest Xray.

A skin test reaction of 10mm. or more of induration, regardless of BCG status, should be considered a true positive for purposes of prophylactic treatment. Positive skin test reactors through age 21 should receive a chest Xray, and other evaluation as needed, to rule out active disease. Persons though age 21 infected without disease should receive one year of preventive therapy. (This is true up to age 35 if reliable monitoring for side effects of isoniazid can be arranged.) All persons with active disease should receive at least 12-18 months of therapy, with at least two drugs, chosen with the aid of drug susceptibility tests. Smear positive cases should be treated with three drugs.

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Immunization

Physicians should not assume that this has been accomplished. Active steps, including follow-up, should be taken to insure that children have received a full series for measles, rubella, mumps, pertussis (under age six), diphtheria, tetanus and polio. Adults should receive tetanus and diphtheria toxoids.

Intestinal Parasites

Most are detected by stool examination. Although multiple stool examinations will detect more infections, treatment is not advised for many helminths unless egg counts are high, and those with high counts should be positive with a single specimen. *Ascaris* should be treated if present at all, and hookworm and *Trichuris* should be treated if large numbers of eggs are present. Mebendazole (Vermox) may be used to treat all three (plus pinworms) if the patient is not pregnant. Giardia may be treated with one of three drugs: quinacrine hydrochloride (Atabrine), metronidazole (Flagyl) or fluorazolidone (Fluroxone), but all three have disadvantages. A recent article suggests quinacrine hydrochloride for giardia in adults, and fluorazolidone for children.[1] Other parasites, including *Clonorchis sinensis*, should not be treated unless symptoms are present. Consultation on recommended treatment for other parasites is available through the Acute Disease Epidemiology Unit at 612/296-5414.

Malaria and Venereal Disease

There have been very few clinical cases of malaria, syphilis or gonorrhea reported in Minnesota's SE

Asian population. Screening for these conditions is of secondary importance unless clinically suspected.

Leprosy

This has been uncommon so far. We are aware of only one case residing in Minnesota. The disease is detected by inspection of the skin. Macular depigmented lesions, particularly if anesthetic to pinprick, or nodules along the course of major peripheral nerves should suggest further work up.

Inspection for lice and scabies is suggested, although these conditions may also be uncommon.

Services for interpreters may be obtained through Catholic, Lutheran and International Institute social service organizations in various parts of the state. Information relating to social service or public welfare may be obtained from Jane Kretzmann, Minnesota Department of Public Welfare (phone 296-8140).

The Hennepin County Chest Clinic (phone 348-3031), the St. Paul Model Cities Health Clinic (224-4601), and the St. Paul Health Department (227-7741) provide screening services for residents of their areas.

In addition to standard medical or tropical medicine textbooks, or texts such as *Current Therapy*, recommendations and dosages for treatment of parasitic conditions are contained in the *Handbook of Antimicrobial Therapy* published by *The Medical Letter* (1978).

Advice on treatment of tuberculosis can be obtained from Dr. H. Richard Johnson, tuberculosis consultant to the Minnesota Department of Health (612) 348-3031. Tuberculosis is a reportable disease and should be reported without delay to the local public health agency and/or to the Minnesota Department of Health (612) 296-5414.

References

1. Wolfe, M.D.: Giardiasis. Pediatric Clin of North Am 26:295, 1979.

2. Barrett Connor, E: Latent and Chronic Infections Imported From Southeast Asia. J Am Med Assoc 239:1901, 1978.