doi.org/10.58931/cibdt.2025.3244

ABOUT THE AUTHOR

Catherine Rowan, MB BCh BAO, MD, MRCPI

Dr. Rowan is an Irish-trained gastroenterologist and general internal physician, with a sub-specialty interest in Inflammatory Bowel Disease. She was the Present-Levison Advanced IBD fellow at Mount Sinai Hospital, New York where she focused on complex IBD care and chromoendoscopy. She was subsequently appointed to the advanced IBD fellowship in the University of Calgary, with a specific focus on IBD care for special populations and intestinal ultrasound. Dr.Rowan currently works as a consultant gastroenterologist and IBD specialist in Beaumont Hospital, Dublin, Ireland where she is department lead in intestinal ultrasound and endoscopy training.

Affiliations: *Department of Gastroenterology, Beaumont Hospital, Dublin, Ireland*

Travelling with Inflammatory Bowel Disease: Clinical Considerations

Catherine Rowan, MB BCh BAO, MD, MRCPI

Key Takeaways:

- Pre-travel consultation is essential for safe and enjoyable travel. IBD patients and physicians should discuss necessary vaccinations and action plans as soon as possible.
- Preparing for travel by packing a medical kit, necessary medications and obtaining adequate travel insurance can reduce stress and mitigate problems.
- Pre-travel vaccination is an important part of the preparations for many IBD patients. Live vaccines are contraindicated in patients taking immunosuppressant medications. Expert advice from a travel medicine specialist can identify individual patient vaccinations needs.
- There are several resources available to physicians and patients alike, to empower our patients and remove many of the barriers they face when travelling.

Introduction

Travel patterns have shown a sustained increase in annual volumes. In 2023, global tourism data show that the number of people travelling has increased to 1.3 billion arrivals, approaching levels seen before the COVID-19 pandemic.[1] A significant proportion of travellers, approximately 18% of those visiting developing countries, have a chronic illness.[2] In a survey by Greveson et al, most individuals with inflammatory bowel disease (IBD) reported that their diagnosis impacted on both their travel behaviour and choice of destination, particularly among those on immunosuppressive therapy. Despite this, only 23% of patients sought medical advice prior to their journey.[3] IBD patients report a number of barriers to travel. Medications, and the implications for infection and vaccination, access to clean toilet facilities, food availability, and appropriate medical services are the most commonly cited concerns.[4,5]

While the majority of patients remain well during their travel, a significant minority report travel-related illnesses. A study by Ben-Horin et al reported that the vast majority of recorded illnesses amongst patients with IBD were enteric in

nature.[6,7] Identified risk factors were elevated fecal calprotectin levels, frequent flares of IBD, and hospitalization due to IBD.[6,7]

Travel is an important and often necessary part of our patients' lives, be it for leisure, visiting friends or relatives, education, or business. The European Crohn's and Colitis Organisation recommends that patients with IBD receive pre-travel counselling and consult national and WHO guidelines.[8] However, a survey revealed that only half of gastroenterologists provided travel-specific advice to IBD patients, with varying levels of accuracy.[9] This article outlines general travel advice and specific points relevant to patients with IBD, aiming to support safe and enjoyable travel.

Preparation for Travel

People with IBD should discuss upcoming travel plans with their IBD care team as early as possible to facilitate safe travel. The specific advice will vary based on the patient's individual needs, duration of travel, destination, and current medical therapy. Conducting preliminary research based on the travel destination and the purpose of their journey can alleviate some of the stress associated with travel and inform decisions around whether a specialist pre-travel health consultation is required.

Important considerations include: **a)** local health services and physicians, **b)** emergency plan and travel kit, **c)** travel insurance, **d)** vaccinations, and **e)** medications.

Local Health Services

Health services can vary widely across the globe. Therefore, it is important for patients to familiarize themselves with the medical system infrastructure at their destination. It is also advisable to research local hospitals and gastroenterologists/IBD physicians in advance of their departure. As the patient's primary gastroenterologist, you may be able to recommend colleagues who work in that area. Otherwise, several resources are available to help patients identify local expertise such as the International Association for Medical Assistance for Travelers (**https://www.iamat.org**) or IBD Passport (**https://www.ibdpassport.com**). IBD Passport is a UK-based non-profit organization that provides evidence-based travel advice for patients with IBD, including country specific advice and a directory of IBD centres worldwide.[10]

Emergency Plan

Planning for an emergency can reduce stress and uncertainty associated with unexpected IBD flares while travelling. In addition to identifying local health resources and gastroenterologists, it is helpful to have contact details for local emergency medical services and the name and address of an adequately resourced local hospital. Patients should also have the name and contact details of their primary gastroenterologist/IBD physician to facilitate communication between healthcare professionals. A summary of their medical condition and a list of their current prescriptions can also be helpful.

Patients can prepare a travel medical kit as part of their carry-on luggage, containing loperamide, oral steroids (prescribed by a physician where appropriate), oral rehydration solution (ORS), oral antibiotics (for traveller's diarrhea), "Can't Wait" card, among others.[10] A "Can't Wait" card explains that the holder has a medical condition requiring urgent access to toilet facilities. It can be presented in stores and public places and is available in several languages.[10]

As part of travel preparations, it is worthwhile to develop a written action plan in collaboration with your patient (**Table 1**). This document should provide guidance for patients on how to identify and manage symptoms and it should be easily accessible to them, ideally as an electronic copy. The action plan can include a triage system that triggers appropriate responses, such as immediate medical assessment in the event of severe abdominal pain and fevers.

Travel Insurance

Adequate travel insurance is critical, even for short journeys. Travel insurance should cover medical evacuation and repatriation in the event of death. However, previous UK-based surveys found low uptake of travel insurance amongst people with IBD,[3] with nearly half of patients travelling without coverage and 7% being denied insurance altogether.[4] Pre-existing medical conditions such as IBD may affect health insurance, affecting both premiums and coverage.[11] An international survey of IBD patients reported that >70% of patients paid insurance premiums.[5] Patients should carefully review their policy and contact their insurance

Symptoms	I feel well, and my symptoms are stable	• Diarrhea • Abdominal cramps • Nausea, vomiting	• Bloody diarrhea • Fevers/chills • Severe abdominal pain/tenderness • Unable to keep fluids down
Actions	Continue my regular medication	Continue my regular medication	Seek medical attention immediately
		Stay hydrated by drinking bottled water and electrolyte solutions	Continue my regular medications
		Add extra salt to my diet	Contact IBD team
		If symptoms persist for >2 days speak with a local doctor	
		Contact IBD team	

Table 1: example of travel action plan; *courtesy of Catherine Rowan, MB BCh BAO, MD, MRCPI.*

agency to clarify how their IBD affects their coverage before travelling, preferably obtaining a written agreement or explanation to avoid subsequent issues with claims. Patients should always have the contact information of their insurance company readily available.

Travel Vaccinations

Pre-travel vaccination discussions should include those that are part of the routine vaccine schedule for healthy adults (not planning to travel) and those specific to the patient's travel plans and destination. An additional consideration for IBD patients is the use of immunosuppressant therapy, which precludes the administration of live vaccines.

Routine Scheduled Vaccines

Influenza is commonly acquired during travel. In temperate climates the peak influenza season is typically autumn and winter. Travellers should bear in mind that these seasons occur at different times in the northern and southern hemispheres. In contrast, tropical climates can experience year-round influenza circulation.[12] Influenza vaccination programs are effective and annual influenza vaccination is encouraged for patients. In addition, practicing good hand hygiene and respiratory etiquette can help to reduce the risk of influenza infection.

Travellers who are due for COVID-19 vaccination should aim to complete the vaccination at least 2 weeks prior to travelling.[13] Pneumococcal vaccination (pneumococcal conjugate 20-valent vaccine) is recommended for those >65 years, as well as for patients of all ages who are receiving immunosuppressive therapy.

The Hepatitis B vaccine should be offered to those who are not already vaccinated, particularly when travelling to an endemic area. If needed, it can be administered in combination with the Hepatitis A vaccine.[13]

Measles mumps and rubella present an ongoing risk in many countries. Travellers who have not had two doses of the measles, mumps, rubella (MMR) vaccine, or who lack laboratory-confirmed measles infection or laboratory-confirmed immunity, should receive the MMR vaccine, unless contraindicated. Vaccine requirements will depend on the travellers date of birth (full details are available in the Immunization of travellers: Canadian Immunization Guide website).[13] Similarly, varicella vaccination is recommended for susceptible travellers. However, both the MMR and varicella vaccines are **live attenuated** and are therefore **contraindicated** in patients receiving immunosuppressant therapy, making careful assessment essential for the IBD population.

A booster dose of the tetanus, reduced diphtheria, reduced acellular pertussis (Tdap) vaccine is recommended for those who have not received it in adulthood to prevent pertussis. Depending on their prior immunization status, travellers should also receive primary immunization or a booster dose of tetanus and diphtheria vaccines.

For poliomyelitis, the inactivated polio vaccine is recommended for incompletely or non-immunized adults, particularly if they are travelling to an area where poliovirus is circulating or if they are at higher risk, such as military personnel.[13]

Travel-specific Vaccines

These vaccines are indicated based on the traveller's destination, itinerary, and the legal or visa requirements of the destination country. They may include booster doses of routine childhood vaccines, such as meningococcal and poliomyelitis vaccines. For travellers who have previously been immunized against polio and are travelling to an area where polio is circulating or are at higher risk, such as military personnel, a single booster dose of the inactivated poliomyelitis vaccine is recommended.

Meningococcal vaccination is important for travel to regions with increased risk. This includes: Sub-Saharan Africa, where outbreaks are common, and Saudi Arabia, where proof of immunization is an entry requirement for those travelling for pilgrimage and for seasonal workers, among others. Entry into Saudi Arabia requires one dose of the quadrivalent meningococcal quadrivalent conjugate (Men-C- ACYW) vaccine, along with valid proof of vaccination.14 Otherwise, the decision to administer the Men-C-ACYW or a multicomponent meningococcal vaccine will depend on the risk of meningococcal disease in the destination area.

The yellow fever vaccine is a **live** vaccine. It is recommended for personal protection against infection when travelling to endemic areas, based on individual risk assessment. Moreover, under the International Health Regulations, proof of yellow fever immunization is required for entry into several countries. The list of these countries is updated annually and is available on the WHO International Travel and Health website. Proof of yellow fever vaccination must be documented using the International Certificate of Vaccination or Prophylaxis. For individuals with a medical contraindication to yellow fever vaccination, such as IBD patients receiving immunosuppressive therapy, an International Certificate of Medical Contraindication to Vaccination can be issued by designated Yellow Fever Vaccination Centres.[13] Travellers should discuss the need for the vaccine with a travel medicine specialist and obtain a valid certificate of immunization or exemption prior to travelling. Without valid documentation, travellers may be refused entry to a country, quarantined, or face other restrictions.[13] Travel medicine specialists should be fully informed of the patient's history and relevant medications, as inappropriate administration of the yellow fever vaccine has been reported in up to 27% of cases.[15]

Additional vaccines may be recommended, depending on the traveller's itinerary, such as the Japanese encephalitis vaccine. As with yellow fever vaccination, consultation with a travel medicine specialist is essential to determine which vaccines are recommended and to assess any contraindications based on the individual's health status.

Medications and Stoma Supplies

Travellers with IBD are advised to discuss their travel plans with their IBD physician to ensure uninterrupted care during travel. They should carry a sufficient supply of their medications for the entire duration of travel, packed in their carry-on luggage to ensure it is available at all times and to prevent loss/damage. A typed and signed letter from an IBD physician is helpful in explaining the necessity and type of their medications to customs or security personnel.

Medication storage requirements vary depending on the specific treatments a traveller is using. Some medications require strict temperature control, and the use of cooler bags may be necessary to maintain a stable temperature during travel (**Table 2**). Discussion with the IBD pharmacist, physician, or patient support program is essential in this regard.

For travellers receiving intravenous infusions, adjusting the infusion schedule in advance can help avoid missed or delayed treatments during the travel period.

Similar preparations are advised for patients with stomas. Patients should carry an ample amount of stoma supplies, preferably in their carry-on luggage. Since items such as scissors are restricted in hand luggage, patients are advised to pre-cut stoma bags and flanges in advance of travel. Healthcare physicians can provide a written letter to explain the presence of a stoma and the need for additional supplies, which can be helpful when navigating security protocols.

Medication	Temperature	Stability	Precautions
Adalimumab (Humira®, Hyrimoz®, Abrilada®, Amgevita®, Hulio®, Idacio®, Hadlima®, Simlandi®)	Keep refrigerated at 2–8 °C, protected from light	Can be stored at room temperature (25 °C) for up to: • **14 days:** Humira®, Amgevita®, Hadlima®, Hyrimoz®, Hulio®, Simlandi® • **28 days:** Idacio® • **30 days:** Abrilada®, Yuflyma®	DO NOT FREEZE
Golimumab (Simponi®)	Keep refrigerated at 2–8 °C, protected from light	Can be stored at room temperature (25 °C) for up to 30 days	DO NOT FREEZE
Ustekinumab (Stelara®, Steqeyma®, Wezlana®)	Keep refrigerated at 2–8 °C, protected from light	Can be stored at room temperature (30 °C) for up to 30 days	DO NOT FREEZE
Vedolizumab (Entvyio®, subcutaneous injection only)	Keep refrigerated at 2–8 °C, protected from light	Can be stored at room temperature (25 °C) for up to 7 days	DO NOT FREEZE
Infliximab (Remsima®)	Keep refrigerated at 2–8 °C, protected from light	Can be stored at room temperature (25 °C) for up to 28 days	DO NOT FREEZE
Risankizumab (Skyrizi®)	Keep refrigerated at 2–8 °C, protected from light	Can be stored at room temperature (25 °C) for up to 24 hours	DO NOT FREEZE
Mirikizumab (Omvoh®)	Keep refrigerated at 2–8 °C, protected from light	Can be stored at room temperature (30 °C) for up to 14 days	DO NOT FREEZE

Table 2. Storage requirements for commonly used saubcutaneous medications; *courtesy of Catherine Rowan, MB BCh BAO, MD, MRCPI.*

Precautions During and After Travel

Traveller's Diarrhea

Traveller's diarrhea (TD) is one of the most common travel-associated illnesses, affecting approximately 30–70% of travellers depending on factors such as destination and season, among others.[16] The majority of TD cases (75–90%) are caused by bacterial pathogens, while viral pathogens account for 10–25% of infections. The most common causative bacteria are *Escherichia coli*, *Campylobacter jejuni*, *Shigella* species, and *Salmonella* species. TD is typically associated with the ingestion of contaminated food or water.[17] Risk factors for TD include:

a. Poor hygiene practices in restaurants
b. Lack of sanitation infrastructure
c. Lack of handwashing/facilities
d. Lack of safe, potable water
e. Unreliable/unsafe food storage facilities

To reduce the risk of TD, Traveller's should take the following precautions:

a. Eat food that is well cooked and served hot
b. Practice rigorous hand hygiene
c. Drink only safe water (boiled, disinfected, or from a commercially sealed container), including for brushing teeth
d. Avoid tap water, as well as ice, or beverages made with tap water
e. Avoid high-risk foods, such as raw/unpasteurized food, mayonnaise, salads, food that has been left out for extended periods

TD usually resolves within a few days, and mild cases can often be managed with standard self-treatment.

Recommended self-treatment includes:

a. **Oral rehydration solutions (ORS):** These should only be prepared using safe water (boiled, disinfected, or from commercially sealed containers) and pre-packaged oral rehydration salts. While ORS is typically available from pharmacies in most low-middle income countries, it is advisable to purchase them prior to travelling.
b. **Anti-motility agents:** Loperamide can be used for symptomatic control but should be avoided if there is bloody diarrhea or fever.

Short courses of antibiotics can be used judiciously to treat moderate to severe TD, and self-medication with antibiotics should be offered to IBD patients.[8] Commonly used antibiotics include azithromycin, fluoroquinolones, and metronidazole. However, travellers with IBD who have bloody diarrhea, fever, or severe abdominal pain should seek immediate medical attention.

Thrombosis

There is a modest but dose-dependent link between travel and venous thrombus embolism (VTE),[18] with the risk of VTE increasing by approximately 18% for each 2 hour increase in travel duration.[19] The risk of travel-related thrombosis is higher in travellers with pre-existing risk factors. Currently, there are no specific guidelines governing VTE prophylaxis in IBD patients who are travelling. However, existing guidelines suggest that maintaining mobility during travel is an effective prophylaxis for VTE. The use of graded compression stockings is recommended for those at higher risk of VTE. Pharmacological prophylaxis is not universally recommended and should be considered based on an individual's risk profile. The use of anticoagulation is favoured over anti-platelet agents in these circumstances.[20]

Tuberculosis

Tuberculosis (TB) is endemic in much of the world and remains a major global health issue.[21] It is routine practice to screen for and treat latent tuberculosis infection (LTBI) prior to initiating biologic therapy.[8] TB risk assessment should begin prior to travel, taking into account the destination and proposed activities. Individuals at high risk of exposure/infection should undergo LTBI, if it has not already been performed. When prolonged exposure to persons with TB is anticipated during travel, risk reduction strategies, such as the use of personal protective equipment, should be implemented.[22]

Unfortunately, cases of presumed primary TB have been reported in patients with IBD following travel to a TB endemic area.[23] Similar concerns have been observed in other patient cohorts treated with anti-tumour necrosis factor agents.[24] The returning traveller should be assessed for evidence of active TB, and referred for a specialist opinion if there is concern for active infection. In asymptomatic patients with potential TB exposure, testing for LTBI using an interferon-gamma release assay or tuberculin skin test should be performed 8–10 weeks post-exposure.[22] It is reasonable to consider annual TB testing in those patients treated with immunosuppressants who travel or work in TB endemic areas.[8]

Discussion

Travel is a necessary part of life for many patients with IBD. Pre-travel counselling has been shown to improve outcomes for patients with chronic illnesses. Unfortunately, many gaps remain in pre-travel guidance for IBD patients. This is evidenced by surveys revealing that 63% of patients were unaware that live vaccines are contraindicated while taking immunosuppressive therapies.[4] Indeed, most gastroenterologists are uncertain about which vaccines are appropriate in a given situation. For example, 50–70% of gastroenterologists were unaware that oral typhoid, yellow fever, and Bacillus Calmette-Guérin (BCG) vaccines were contraindicated in patients taking immunosuppressive therapies.[9] IBD nurses and physicians remain the primary source of travel advice for patients, followed by general practitioners.[5] These findings highlight that education for both physicians and patients is imperative to ensure safe and enjoyable travel for IBD patients.

IBD teams should encourage patients to discuss travel plans well in advance to allow ample time for appropriate preparation and administration of vaccinations. Several resources are available to support both patients and healthcare providers, including patient foundations and government

Travel Guidance Resource
International Association for Medical Assistance for Travelers (**https://www.iamat.org**)
Canadian Embassy/Consulate (**https://travel.gc.ca/assistance/embassies-consulates**)
Government of Canada Travel & Tourism (**https://travel.gc.ca/**)
IBD Passport (**https://www.ibdpassport.com**)
Crohn's and Colitis Canada (**https://crohnsandcolitis.ca/About-Crohn-s-Colitis/IBD-Journey/Travel-and-Lifestyle/What-to-Bring**)
Crohn's and Colitis Foundation (**https://www.crohnscolitisfoundation.org/what-is-ibd/traveling-with-ibd**)
WHO International Travel and Health (**https://www.who.int/health-topics/travel-and-health**)
Travel Health Pro (**https://travelhealthpro.org.uk/countries**)
Ileostomy & Internal Pouch Association (**https://iasupport.org/wp-content/uploads/2020/11/TravelTips.pdf**)

Box 1. Travel guidance resource; *courtesy of Catherine Rowan, MB BCh BAO, MD, MRCPI.*

travel advisories. However, many patients remain unaware of travel services such as the "Can't Wait" card or the IBD Passport, which can be easily provided during a pre-travel consultation.[4] **Box 1** includes helpful travel resources covering topics such as local healthcare services, vaccinations, and basic travel precautions.

Routine vaccinations are part of a patient's pre-travel consultation. However, vaccine uptake can be affected when responsibility for the vaccine is unclear or divided between general practitioners and gastroenterology teams, making clear delineation of roles paramount. Furthermore, effective communication between IBD teams and travel clinics is crucial to ensure that patients, particularly those taking immunosuppressive therapy, receive safe and complete travel vaccinations and advice.

Many travel-related barriers can be addressed with basic pre-travel counselling and preparation. IBD physicians and nurses can empower patients with information and an action plan to navigate common situations such as travelling with medications, accessing health care, and self-treating TD. A structured, collaborative approach to travel guidance can facilitate safe, enjoyable travel for our patients with IBD.

Correspondence

Catherine Rowan, MB BCh BAO, MD, MRCPI
Email: c.r.rowan@gmail.com

Financial Disclosures

C.R.: Speaker training: Takeda; **Support to attend conferences:** AbbVie, Janssen; **Honorarium for internal publication:** Samsung

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