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Background *Leishmania major* (*L. major*) infection in humans is well-established and results in cutaneous leishmaniasis (CL). We report, to our knowledge, the first naturally acquired case of *L. infantum/chagasi* infection in a returned traveller. As patients present with fever with or without respiratory symptoms, the differential diagnosis should include both viral and bacterial infections. Viruses can cause systemic illness, mimic an infectious process, or result in mild symptoms. This section will focus on the most important viruses in returning travellers based on their seasonal occurrence and geographical spread. Advances in genetic techniques are allowing for more rapid identification of many respiratory pathogens, and should be considered whenever a diagnosis of infection is being considered. These advances will also assist in differentiating between closely related viruses, and will greatly assist in future vaccine development. Not all respiratory viruses are defined to occur in specific geographic locations. The respiratory syncytial virus for example can be found in travelers from all over the world, but has predilection for children in temperate climates. However, if specific risk factors are present such as contact with an infected individual, certain groups of travelers (e.g. pilgrims, attendees of a religious event or ceremony) or contact with a dog, these viruses are more likely to be diagnosed in returning travelers. In the Gulf region, influenza peaks in the winter months and there has been an increase in the number of patients with influenza, including among visiting Haj pilgrims, after the onset of the Hajj. Influenza-like-illness is usually seen between October and May. Because the majority of influenza cases are mild, the vast majority of people recover from influenza in a few days and have only mild to moderate symptoms. There is a winter influenza epidemic for travelers in the Middle East for the first time in the past 5 years, and often the most severe disease is seen in returning pilgrims from Europe. The first cases of influenza A (H1N1)pdm09 (swine flu) were seen in 2009 in Mexico and the USA, but the start of the epidemic of the virus started in the northern hemisphere fall of 2010, and in the Gulf region in 2012-2013. Travel-associated cases of influenza A H1N1/pdm09 have been documented from travelers to Saudi Arabia, Iran and Turkey, and a case from Morocco in a Spanish pilgrim was recently reported. In the USA, this pandemic virus was first seen in 2009 and then became rare until 2011 when a new peak was reported in 2012 and 2013. The circulation of influenza B has been low in the Gulf region for several years, but a new wave has occurred in 2015 in Saudi Arabia, United Arab Emirates, Qatar and Kuwait [ 13 - 16 ]. After the first H1N1 pandemic peak in 2009, cases of influenza B have remained relatively uncommon in the Gulf region until 2014, when a new wave of influenza B occurred [ 17 ]. During 2016, a large outbreak of influenza B occurred in Saudi Arabia (with 47 deaths) [ 18 ], and there was an increase in influenza A H3N2 in Pakistan in November 2016 (with four deaths) [ 19 ]. After the H1N1 pandemic, the circulation of influenza A H3N2 has been low, but since 2013 there has been a return to higher levels of H3N2 activity in the winter months, and in the winter of 2016-2017 the World Health Organization reported two epidemics of influenza A H3N2 (one in the Northern Hemisphere and the other in the Southern Hemisphere) [ 20 ]. The most recent large outbreak of influenza A H1N1/pdm09 in the Middle East occurred in Saudi Arabia in the summer of 2017 [ 21 - 23 ]. The season was relatively mild, with only two deaths, compared to the almost 400 deaths related to the 2009 pandemic.

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