Letter from . . . East Nepal

Silver Jubilee trek to Mount Everest

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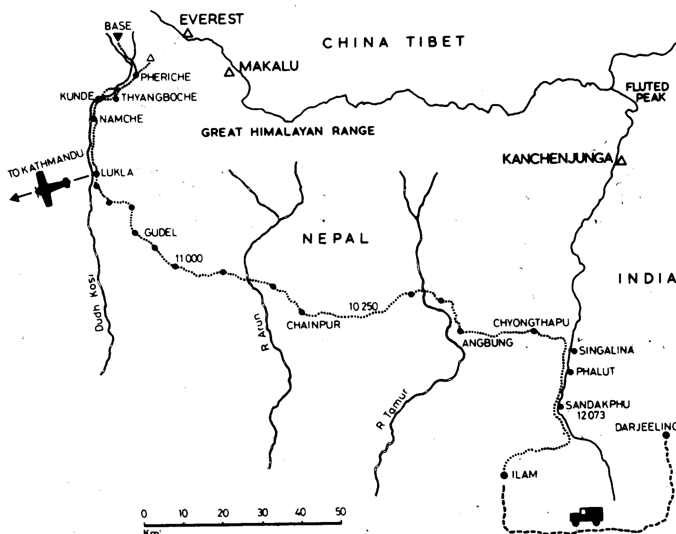
Mount Everest was first climbed in 1953, and in the autumn of 1978 a trek was planned to revisit Solo Khumbu with as many of the original expedition members as could come. Twenty-five years is a long time, and only five members of the 1953 team could make it. I was asked to be the official doctor: in the end Michael Ward came and, as my wife is a doctor, we had the benefit of three medical opinions at all times on subjects ranging from malaria to mountain sickness. This was nearly always a great help. Most members brought their wives, and this made an excellently balanced party of 12, six men and six women.

We planned to walk from Darjeeling to the Mount Everest area, a crow-fly distance of 110 miles, in four weeks, to climb somewhere near Mount Everest for five or six days, and then to return via the notorious Lukhla airstrip to Kathmandu. Three days were allowed at each end for junketings, and four for air travel.

If this seems a long time the beautiful, unknown, and highly mountainous territory of East Nepal must be blamed for it. One hundred and ten crow-fly miles there become 310 miles on foot. In 34 walking days the party climbed a total of 62 300 feet (two and a half Everests) and descended 57 500 feet, this discrepancy being accounted for by the height difference between Ilam (4600 feet), where the walk proper started, and Lukhla (9500 feet), where it ended. On the way we crossed three minor mountain ranges varying in height between 10 and 12 000 feet.

FIG 1—Climbing at 18 500 ft on a steep ridge in Chola Hhola valley.



How would twelve people with an average age of 55 for the men and 48 for the women fare on such a journey? I knew that one of the men suffered from angina and controlled cardiac failure and was under the care of a London cardiologist, who kept sending me long, detailed, and rather worrying letters in the months before the trip started. I need not have taken them so seriously. In fact he was one of our best walkers, I suspect because he was so thin. If one essential prerequisite for Himalayan travel could be singled out it would be thinness. We were nearly all on the skinny side, despite our ages, and the only person who suffered at all during the march in was the one who was perhaps seven pounds overweight for her height.

A trekking day

A trekking day starts at 5 30 am with a light breakfast before moving off at 7 am. The best part of the day's journey is done in the first four hours, best both in distance travelled and in comfort, for it is cool. Lunch is leisurely, with luck by some delightful river where kingfishers, Eurasian rollers, scarlet minivets, black-capped redstarts, and the little forktail will delight those who have binoculars and can recognise what they see. In the afternoon three hours of rather slower plodding is enough. In October and November darkness falls with amazing swiftness in Nepal, at 5 15 pm precisely, and a firmly established camp and water supply are necessary by that time.

Water is often a problem, because the autumn months are very dry, and it may be hard to find. It may be polluted, unless it is running swiftly and far from houses. I firmly recommended

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the use of water purifying tablets at all times, but Lord and Lady Hunt disdained such modern aids, saying that they never used them. Neither suffered from gastroenteritis but nor in the main did the other members of the party. The natives will know where safe water is to be found: let me give a small example. Half way between Lukhla and the immense river Arun lies the village of Gudel. Like many Nepalese villages it straggles across many miles of hillside, and is traversed by several fine torrents. The snag is that every alternate torrent is used by the locals as an open-air lavatory. It pays to know which is which if you are thirsty, or just caught short.

In seven hours walking a day, perhaps 12 miles of extremely up and down hill going can be covered. Anybody who is at all fit should manage this quite easily. After all, the porters are doing it with 60 pounds on their backs. We all lost about seven pounds in weight on a diet consisting largely of rice, lentils, oatmeal, puris, and the occasional slaughtered chicken or goat. Good teeth are essential because they work overtime, and should be checked before leaving England.

FIG 3—Porters crossing bridge over river Tamur in East Nepal.

Nepalese medical services

There are few dentists and doctors in Nepal. It certainly is not a country in which it would be wise to have a serious illness. One of our members contrived to have an intussusception of his bowel in Delhi on the return journey, a complication that only occurs in children I am told. My friend Dr Dermott Grene of the British High Commission Hospital in Delhi came to his rescue. After intravenous treatment lasting 48 hours two feet of bowel were removed, and he was back at his desk in London within three weeks. If this had happened in East Nepal he would have died. There are no roads or telephones, and it would have been necessary to send a runner to the nearest radio station. Here he would have summoned a helicopter if there was one. An abdominal emergency such as this is the nightmare of every trekking doctor. Most equip themselves on a shoe-string budget with a medical kit that does not include oxygen or intravenous fluids. How could they carry either out from England on a standard baggage allowance of 44 pounds? Their medical lists are all very similar[1 2] (see appendix 1). Next time I would take some anthelmintics and iron tablets. Dr John Dickinson, who knows so much about medicine in Nepal, put it rather succinctly, "Low-level porters paddle in rice fields so they get hookworms and bleed PR. Tibetans wear boots, it's too cold for rice to grow, but they love uncooked pork and so harbour tapeworms."

I was lucky enough to meet him at his hospital, the Shanta Bhawan in Kathmandu, at the end of our trek. If anybody understands the organisation of medicine in Nepal, he does, and he has outlined the problems and what steps have been taken to solve them.[3] There is a Government medical service run by the Department of Health Services of His Majesty's Government of Nepal. This, the NHS of Nepal, runs four or five hospitals in Kathmandu and has tried to place at least one district hospital or aid post in each of the main districts of Nepal. Thus Ilam is the capital of Mechi, the most eastern district of Nepal, and one would hope to find a hospital there. It has not yet arrived. Much emphasis is placed on the training of paramedicos or barefoot doctors to fill the awful gaps in a country with a doctor: patient ratio of 1:150 000 in rural areas. We met two of these on the path between Chyongthapu and Angbung. They were well-dressed young men carrying satchels. Inside one satchel were a few dressings, two packets of birth pills, and some condoms. Birth control is an important part of the Government medical service, but it has made little progress so far in a largely Hindu country with a high infant mortality, where a man's first priority is to make sure that he has live sons to dispose of his body in the proper manner when he dies.

The United Mission to Nepal is an entirely Protestant charitable organisation that has four hospitals, one of which is the Shanta Bhawan. The Himalayan Trust was set up in New Zealand by Sir Edmund Hillary. Among other things it runs the Sherpa hospital at Kunde, with which I was to make close contact during our trek. The British-Nepal Medical Trust is chiefly concerned with tuberculosis eradication, and operates five clinics for this in rural areas. (We visited one in Chainpur.) It also finances the Hill Drugs Scheme, which has 25 chemist shops in small villages stocked with inexpensive medicines. In addition there are Ayurvedic doctors following the ancient herbalist traditions, indigenous midwives, and witch doctors.

FIG 2—Members of party at start of trek. Left to right back row: Lord Hunt, Susan Bank, Da Namgyal, Michael Ward, Sheila Wylie, Mary Nicol, Hamish Nicol. Front row left to right: Pinjoo (Sirdar) Tenzing, Lady Hunt, Mingma, Jennifer Bourdillon, Sally Westmacott, Michael Westmacott.

Medical trekking problems

How much use is all this to the trekking doctor? If he is lucky not much. He should be able to look after 100% of all illness in his group of Europeans, Sherpas, and porters. If he is landed with an acute abdomen he will try to get the patient evacuated by air. There is a first-class British Military Hospital at Dharan in Kosi district of East Nepal. The Shanta Bhawan in Kathmandu has a high reputation, but it is grossly overworked. Any European living in Kathmandu who knows the ropes and has a surgical or gynaecological problem finds his way automatically to either Hong Kong or Delhi for operation.

On this 25th jubilee trek, I was one of the lucky doctors and had little to do. Constipation from the unaccustomed diet of polished rice was our chief intestinal problem in the first three weeks. By day four, I had dealt with a minor attack of piles, one of cystitis, and a delicate Sherpa with a cold. The local population were so unsophisticated that they did not form queues at my tent as they do in more touristy areas. A case of tuberculosis

was directed to the clinic at Chainpur and a porter with gastroenteritis got better with co-trimoxazole, despite what they say in books.

A few miles west of Chyongthapu we nearly lost Jennifer. She tripped on a very steep bit of path and the next moment was sailing through the air. Fortunately, she came to rest in the branches of a tree 20 feet down. George Band managed to pull her to safety but she could easily have been killed. Every year steep paths and grotty bridges take their toll in Nepal. Tourists who are not used to the conditions should be very careful, wear strong walking boots, and avoid floppy jeans.

Strong boots help to ward off leeches that enter anything. They will even worm their way through the eyelet-hole of a gym shoe. One evening, playing a game of poker dice, Michael Westmacott passed me "Two Queens, two Jacks—and a leech." The creature had somehow climbed up a packing case that was serving as a table. A leech once discovered is easily dispatched. A lighted cigarette end will do it, but there were no smokers among us. It is better perhaps to smother it with salt. This kills instantly by osmosis and dehydration, and it is painless too, to the host.

Usually the illnesses I dealt with were simple and very like the problems any GP encounters in England—sinusitis, bronchitis, otitis media, minor orthopaedic disabilities, and a patient with malaria who had been down to the Terai. Malaria is endemic in Nepal below 4000 feet, but it is not unknown in Britain.

After three weeks' walking we reached the airstrip at Lukhla, and were in Solo Khumbu proper. Here, tourists of all nationalities arrive in hundreds every day, and even the little children have learnt how to beg. Namche Bazaar is the first of the Sherpa villages proper. Beyond it lies Kunde, a bleak place where at 12 600 feet very little grows except potatoes, juniper, and berberis. Long before reaching the hospital at Kunde I was aware that something was wrong. A doctor was needed at the hospital urgently. The RSO was away for the day, and his wife was trying to deal with a Sherpani primigravida in labour. Late that evening she had her baby by the breech, with forceps to the aftercoming head. It reminded me of the 1950s and 1960s back in England, when a GP was still allowed to deal with anything short of caesarean section himself.

At Kunde the party split into three groups. Two low-level groups explored the Sherpa villages. The climbers set up a base camp at a height of 16 500 feet in the Chola Khola valley that lies immediately to the west of Mount Everest. Here they stayed for five days and climbed cols and mountains in the vicinity, all nameless, and most unclimbed. At night the temperature dropped to −13°C, and by day it scarcely rose to freezing point, though the skies were clear and blue.

Now that mountain sickness is so much discussed and studied I was anxious to note its effect on our aging mountaineers. Alas, apart from shortness of breath, only one wife suffered from headaches and sleeplessness over 16 000 feet. Nobody else was at all affected. This proves at least one thing—that it pays to approach your mountains slowly, and on foot.

Appendix 1

MEDICAL LIST OF DRUGS TAKEN

The drugs were put into strong plastic bags, and the whole kit was carried in a nylon kitbag. (Heavy canvas would have been better: yaks are very destructive.) Total weight 12 kg (26 lb).

Bag 1

Antibiotics—benethamine penicillin (Triplopen) inj 10 phials, ampicillin/flucloxacillin (Magnapen) inj 10 phials, aqua dist 2 ml × 10, chloroquine tabs 50, nalidixic acid (Negram) 100, oxytetracycline 200, ampicillin 100, co-trimoxazole/sulphamethoxazole/trimethroprim (Septrin) 200, cloxacillin 75, erythromycin 100, flucloxacillin (Floxapen) 50, penicillin V 100, metronidazole (Flagyl) 100. Paediatric sachets of ampicillin and amoxil.

Bag 2

Analgesics—paracetamol (Panadol 100, Para-Hypon 40, Solpadeine 20), dihydrocodiene tartrate (Paramol 118) 50, pentazocine (Fortral) inj 60 mg × 10, tabs 100.

Cardiovascular agents—digoxin tabs 0·25 mg × 100, digoxin IV 2 phials, frusemide (Lasix) inj 20 mg × 5, tabs 50, bumetanide (Burinex) phials 2, aminophylline IV 2 phials.

Antiallergic agents—hydrocortisone succinate inj 5 phials, prednisolone tabs 5 mg × 100, adrenaline inj 1/1000 5 phials, promethazine (Phenergan) tabs 100.

Eye drops—chloramphenicol 3, betamethasone (Betnesol) 2, physiological saline 3, amethocaine, bacitracin (Neobacrin) 2, fluorescein 2.

Bag 3

General anaesthesia and hypnotics—IV butterfly needles 2, CT1341 (Althesin) phials 2, airways number 2, number 3, diazepam (Valium) 2 mg tabs 50, (Valium IV) 5 phials, flurazepam (Dalmane) 30 mg 100, nitrazepam (Mogadon) 100, promethazine (Phenergen IV) 2 phials, promazine (Sparine) inj 100 mg × 2, promethazine theolate (Avomine) tabs 30.

Local anaesthesia—lignocaine gel 1, (Xylocaine 2%) 2 cc × 10 and 50 cc multidose bottle.

Skin preparations—betamethasone (Betnovate) cream 30 g, clobetasone (Molivate) cream 25 g, miconazole (Daktarin) powder, bacitracin (Neobacrin) unguent 1, dibromopropamidine isethionate (Brulidine) cream 1, methyl nicotinate (Algipan) 1, mepyramine (Anthisan) cream 1.

Gynaecological agents—clotrimazole (Canesten) pessaries 12, ergometrine maleate (Syntometrine) 3 phials, plastic gloves 2.

Bag 4

Dressings—elastic adhesive 2 in × 1, 3 in × 2, micropore 2, triangular bandage 2, lint dressings 2, Kling bandages 9, crepe bandages 10, gauze packets 7, cotton wool packets 6, sofra-tulle 12, stockinette 2 sizes, bacitracin (Cicatrin) powder, ribbon gauze, Elastoweb bandage 1.

Bag 5

Chest and respiratory tract agents—amphetamine sulphate (Benzedrine) inhalers 4, salbutamol (Ventolin) inj 5 phials, terbutaline (Bricanyl) tabs 50.

Gastrointestinal agents—diphenoxylate (Lomotil) 400, senna fruit (Senokot) 100, bisacodyl (Dulcolax) suppos 6, hydrotalcite (Altacite) 100, metoclopramide (Maxolon) tabs 50, codeine phosphate tabs 100.

Rectal agents—betamethasone (Betnovate) rectal ointment 2, fluocortolone (Ultraproct) suppos 24, syringes 2 ml × 4, 10 ml × 5, needles, spare tablet bottles.

Bag 6

Anti-parasite preparations—gamma benzene hexachloride (Lorexane) cream 1, piperazine hydrate (Pripsen) granules 2.

Miscellaneous—Lantex tissues 6, chlordrexide gluconate solution (Medi-Prep) 20, dequalinium chloride (Dequadin) lozenges 20, oil of cloves, vitamin C 50 mg × 50.

Bag 7

Plaster of Paris 6 in × 3, 4 in × 3, plaster wool 3, long Polythene leg splint 1, box of strip dressings.

Appendix 2

MEMBERS OF THE PARTY

Lord and Lady Hunt, Col Charles and Sheila Wylie, George and Susan Band, Jennifer Bourdillon, H G and Mary Nicol, Michael Ward, M H and Sally Westmacott, Sirdar, 11 Sherpas, 50-60 porters.

References

[1] Steele, Peter, *Medical Care for Mountain Climbers*. London, Heineman, 1976.

[2] Hull, F M, *Update*, 1 May 1978.

[3] Dickinson, John, *British Medical Journal*, 1976, **2**, 1364.