A far off place

JONATHAN NORTH

It would make a good viva question. "You are at an altitude of 5400 m (18 000 ft) and a member of an expedition to which you are the doctor. You are in a snowscape; the only sights are snow covered peaks, and the only sounds the crackle of ice and the rumble of distant avalanches. Three hours before one man has collapsed with a severe headache of sudden onset; he is semiconscious, dysarthric, has signs of severe meningism, and is developing a hemiplegia. Greatly helped by his partner he has abseiled down the mountain face and walked for an hour to his present location, where he has finally collapsed. The nearest roadhead is two days away and the nearest hospital three days away. You are in Peru. What would you do, doctor?"

"Geoff's almost dead," I said, clear, decisive, cutting through the dead wood, but, on the whole, not boosting morale. The expedition had been going well until this point; we had had few problems. All the climbers had acclimatised well and I had been allowed to move up to the col of Mount Apalmayo to make a summit bid the following day.

We were a 13 man expedition gaining high altitude experience in the Huscuaran region of the Peruvian Andes; the aim was for all the members to climb Mount Alpamayo. At this time we were split into two groups using a common base camp, and five members of the expedition were climbing Mount Artesonraju. Four of us had spent a relaxing afternoon at the col. "Let's practise crevasse rescue," somebody had joked. "Andy, go and jump in that crevasse." As things turned out it was a poor joke.

Difficult to think straight

It is difficult to think straight when at that altitude. Is this a subarachnoid haemorrhage? Good history, good signs. . . . Has he stopped bleeding? If it is then he will have to be seen by an expert within ten days. Cerebral oedema? He's fully acclimatised. Strange history, but anything goes (or so they say). If it is then he must go down. Migraine? No personal or family history. Still there's always a first time. Meningitis? I suppose it can be caught anywhere. Damn, I didn't have the intravenous antibiotics I might need for this with me, they were at base camp. So what to do?

In the Alps a sneeze brings a helicopter swooping down to rush the sufferer to hospital; here it was a completely different kettle of fish. It became rapidly apparent that bleeping my registrar was not a viable proposition.

As medical students at Addenbrooke's we used to be grilled by a neurosurgeon on the early on the spot management of neurosurgical emergencies. His favourite topic was cervical spine injuries and, having fixed somebody with a steely gaze, in soft Scottish tones he would say, "You are a GP in Cleckheaton, when you are called to a rugby match where a young lad is lying unconscious with his neck at a very strange angle. What would you do, doctor?" There would then be a pause of considerable length as the individual concerned desperately tried to formulate a non-committal answer, before the soft, Scottish tones added, "He's dying, doctor."

Geoff had to go down; he most probably had cerebral oedema. If it was subarachnoid then we hoped that it had stopped bleeding. In any case, rest at this altitude would not do him much good.

To use medical jargon, a policy of rapid descent, rehydration, and analgesic was instituted. In effect this meant that we intended to get Geoff down the mountain as quickly as possible. Each time we stopped he was compelled to drink at least one pint of water and when the need arose suitable medication was provided so that he did not mind what we did. Merv had assessed the evacuation routes; it would take us two weeks to descend north through the glacier and

therefore the only practical choice was back the way we had come. Geoff could still move his legs if supported and therefore he was carried, one man under each shoulder, the 120 m (400 ft) back to our camp on the col. It would be dark in half an hour and Andy had started packing rucksacks of what we would need for descent to the snow line at 4800 m (16 000 ft). Under normal circumstances that descent usually took an hour and included slopes of 70 to 80 degrees at certain pitches.

Pulseless and unresponsive

In order not to delay Geoff's descent Merv started carrying him down towards the snow line. The pair were belayed by Mike. No other members of the expedition knew about the accident and therefore it was essential that a correct message should reach our leader who was at base camp so that further evacuation could be sorted out. Unfortunately, it was not possible to contact base camp from the snow line by radio. I remained a short time on the col until a scheduled radio call and then Giles and I set off at pace (as Nigel Starmer-Smith might say) into the darkness. Below us our three

The evacuation route.

friends were identifiable by their head torches. How on earth were they moving so quickly? I was soon to find that Merv had more or less carried Geoff all the way in an hour—an amazing feat. I couldn't help wishing that I had that ability.

Giles and I, having stayed behind for the radio call, arrived at the snow line fully expecting to discover that Geoff had died. Merv greeted us with the words, "He was pulseless and unresponsive." My heart fell. Merv added with a smile "But he's improved now."

The next 900 m (3000 ft) were treacherous scree slope, which was by now freezing over; it would be impossible to continue that night and as Geoff would have to "walk" again the next day we decided to camp overnight. One of the lads appeared from the base camp guided by a light shone down the mountain; he brought with him additional medical supplies and requested further information.

South west face of Mount Alpmayo.

Then he disappeared into the gloom. John, who had travelled from the base camp that day and who had therefore not known about the evacuation, recounted hearing a voice approaching from above, noting that it was an entirely one sided conversation. What in fact he had heard was Merv desperately urging the last dregs of energy out of Geoff.

To prepare him for the hazards of the next day's journey I gave Geoff a strong sleeping tablet, having decided that a good night's sleep would be essential if he was to make the descent the following morning. I didn't sleep much. Geoff was Cheyne-Stokes breathing, which is common at altitude, and as we lay side by side in our sleeping bags I woke up thinking that he had died every time a long pause in his breathing occurred.

"Geoff?" "Yes, Doc?" He was still alive, he had severe ataxia and dysarthria, a mild hemiplegia, and meningism with photophobia so severe that he had to be blindfolded.

Speed of descent imperative

The vexed question whether or not to use a stretcher reared its head, as it had at the col and would again later. Modern mountain rescue stretchers are excellent and tailor made for casualties. But, having discussed the matter with others on the expedition far more experienced in evacuation than I was, I decided that it would not be manageable over the descent to the advanced base camp and that anyway, as speed of descent was imperative, other means would have to be used.

At first light we started. Merv held Geoff up with a harness, guiding him and telling him where to put his feet. The three of us moved down, the rest of the lads following. I counted at least half a dozen times when Geoff slipped and Merv, maintaining his own balance, held him up almost off the ground, then gently set him down.

A pleasant round of applause greeted Geoff as he was guided into our advanced base camp at 3900 m (13 000 ft), where the rest of the expedition had now assembled. We were still faced with major problems with the further evacuation, because, although Geoff was improving, he was still dangerously ill. It would take another 15 km (9 miles) over difficult terrain to achieve another 600 m (2000 ft)

drop in altitude. It was certainly not possible for Geoff to walk this; a stretcher journey would have again been extremely difficult and very slow.

Giles sorted out the problem by persuading a group of Colombian trekkers that Geoff was more important than their evening meal and thereby the expedition became the proud owners, at least temporarily, of four mules. Our patient sat on one mule and was supported on each side by other members of the expedition. I felt for him. I had once spent 14 hours in the Himalayas on the back of a yak because of a fractured ankle and still bear the scars.

The expedition leader approached me shortly after we set out in the early afternoon. "Is he dead?" he asked. He looked worried. A good reason to worry, I thought. Had I missed something? Surely I wouldn't have missed that. "Get stuffed," said the patient. That settled the argument.

The three spare mules were used to carry our kit, and Geoff alternated between all four. Again, suitable medication was provided so that Geoff didn't mind too much what we did to him. After our six hour journey to our overnight rest place I contracted a bad attack of gastroenteritis. "I hope you're not going wobbly on us, Doc," said Merv. "Don't be ridiculous," I replied, feeling extremely wobbly.

An early start the next day saw us in Cashapampa by midday. Duncan and Brian, who had trekked out the previous day to arrange further evacuation, greeted us with a variety of options. In view of Geoff's condition, however, there was only one choice—to move him to sea level as soon as possible.

"Our man in Lima"

It was therefore with great relief that we heard the sound of a helicopter breaking the silence later that afternoon. How the helicopter was obtained would take too long to describe here. But it takes a very special person, on realising that an expedition might be in serious trouble, to hire a helicopter and set out north, stopping at mountain villages to try to find our location.

After hasty goodbyes, Geoff, "Our man in Lima," the expedition leader, and I made the two hour flight, racing against the gathering

Geoff (left) being lowered down the mountain face.

darkness, to sea level. There was only a minor hiccup rising over a pass at 4200 m (14 000 ft) when I thought for a few minutes that we had lost Geoff. Thankfully, he recovered.

The above account is not meant to sound flippant, but throughout the entire rescue an amazing sense of humour prevailed, notably from Geoff in his more lucid moments. He is alive and well. As we all know it is difficult to break news to patients about serious

illnesses and Geoff could remember nothing of the first 36 hours after his collapse.

As he was convalescing in Lima and we were awaiting a flight home I had tried to establish with him the idea that he had been seriously ill. Although I had not used words like "pulseless," "unresponsive," or "dead," I had made it clear that high altitude climbing in the future was not advisable. This problem had in fact already been solved by his wife, who had already sold all his climbing kit by the time we arrived back in England one week after the incident. But as we were shaking hands at the airport "our man

in Lima," whose help can be described only as inspired, was heard to say to our patient, "Well done, Geoff. For a long time I was certain we'd be sending you home in a box."

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The scorpion story

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When people hear about the expeditions that I have been on they often suggest that I must be an expert in tropical medicine. I usually deflect such accusations by explaining that nothing exciting ever happens to me. Sore throats and colds seem to cause most problems, and travellers' diarrhoea nearly always responds to a day or two on clear fluids, although there was the difficult case of chickenpox that baffled us in the Andes a few years back. The realisation that there are remarkably few noxious animals that can kill a healthy adult made me think that even the remotest jungle must be a friendlier place than the inner cities. During the course of the 1986 Crocodile Caves of Ankarana Expedition to Madagascar, however, I had cause to change my mind and I have become a little less blasé.

A troop of Sanford's lemurs was sitting in a line along a branch, spotlight by sunlight streaming through a hole in the forest canopy. One of the females had a week old infant on her back: a superb photograph, just waiting to be taken. I plunged my hand into my bag for another film.

Suddenly I feel a sharp seering pain in my right index finger and am aware of a scuttling from my bag. The scorpion had drawn blood. I squeeze and try to suck out the poison. Paul, veteran of several tropical expeditions, tells me that I should take some pain killers: "It will hurt." I feel foolish. And what about my photograph? I expected it to be more painful than this. I continue sucking my throbbing finger while the others start exploring my bag for the culprit. I should probably apply a tourniquet, but it's too painful and I don't want to. I consider a lignocaine injection, but I am too cowardly to self administer that. "The nastiest ones have small claws because they rely on their venom to kill their prey." This one has small claws. I don't feel comforted.

Hit with a large hammer

I start to feel a bit strange and decide that it would be sensible to lie down. My finger now feels as if it has been hit with a large hammer. It is swollen and red, and painful streaks are spreading into my forearm. The puncture mark is no longer visible. It is still not too bad but it's getting worse minute by minute. Sweat starts to stream off me and I cannot find a comfortable position. Any angle makes my hand and arm more painful. The pain spreads into my upper arm and axilla. My left hand and feet are tingling too and my back aches. I feel bad. I kneel up, lie down, lie propped up, curled up. Take some morphine sulphate. The water to wash the tablets down feels like swallowing hot pins and needles. People look concerned. The tingling must be because I am hyperventilating. I concentrate on breathing slowly. I feel a lump in my throat. My nose

is congested and my eyes stream. Blowing my nose provokes a wave of severe pain in my face. My throat feels tight and I begin to worry that my airway will become obstructed. I wonder if there is any treatment. The books say that scorpion stings are only painful, not

Grosphus palpator.

[Photograph taken by Simon Fowler.]

dangerous. The Chinese man in Diégo-Suarez who sold us the food for the expedition said that if anyone was stung we should crush the scorpion in a pestle and mortar and apply this to the sting site. I suggest this. Paul, with remarkable and disarming faith in the local medical services and our abilities to reach them, said "No. If you get into trouble, Jane, having the scorpion may help the doctors decide on the right treatment." Some hopes. I do not tell him that I think I am already in trouble. Supportive treatment would be the best I could expect. And the nearest doctor is a day away—if I could walk.

"I think I'll have the hydrocortisone." Nervous hands drop the only needle into the leaf litter. An abscess would be the least of my worries. I thrust 100 mg of hydrocortisone into my calf, wondering if anyone else has given an intramuscular injection there before. The injection swab reveals my filthy state. I had just got back to base camp after a hard day's jungle bashing and had been looking forward to a long cool bath in our subterranean bathroom, followed by some cold rice.