

## Rejuvenation Time

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AS THE RECENT PAST PRESIDENT of the International Mountaineering and Climbing Federation (UIAA) Medical Commission, I feel fortunate to have worked together with members of the UIAA Medcom (Medical Commission) and members of the IKAR (International Commission on Alpine Rescue) Medcom and the Wilderness Medical Society. These personal friendships will come in handy in this process of rejuvenation of the International Society of Mountain Medicine (ISMM) so that we work as a team and achieve our goals. The one common goal that we all have is to try and keep the sojourner (climber, trekker, skier, scientist, soldier, pilgrim, porter, office worker or just a “loafer”) safe in the mountains. One way of doing this is by having a user-friendly ISMM website where we have continually-updated standard recommendations (or useful links to standard recommendations) regarding prevention of altitude illness, hypothermia, frostbite, gastroenteritis, and so forth in the mountains. ISMM could also join the UIAA Medcom in work being done on drug use in the mountains. We clearly need to be able to give our members a bang for their buck besides the informative journal, *High Altitude Medicine and Biology*, that we have access to as members. We have now started our list-serve similar to the one that the International Society of Travel Medicine has. This may be a step in the right direction as many members miss the discussion forum in the old ISMM newsletter. This kind of forum may help to engage our members, especially young members, with interesting and practical questions and answers.

Having been excited by the recent success of the Diploma in Mountain Medicine course even in far-flung places like Nepal (where it is also most relevant), we would like to encourage many other countries to also set up these useful courses in their countries so that a certain trained cadre of mountain medicine health professionals will be formed worldwide. In trekking and mountain expeditions, properly trained health professionals can work side by side with mountain guides (as the Europeans have done for decades in the Alps) and be more effective in rescue situations. The ISMM will continue to work even more closely with the UIAA Medcom and IKAR Medcom in this regard. Needless to say, these courses would be very useful in countries where towering peaks abound. But many of these countries are resource-poor, and it would be wonderful if ISMM could help out as a conduit whereby certified mountain doctors could go and volunteer their services in teaching the Diploma courses in these countries.

We will also need to continually encourage collaborative high altitude studies. These studies can span the spectrum from basic high altitude questionnaire-based research (for example the Lake Louise Questionnaire) to sophisticated

genetic studies dealing with polymorphism of genes like EPAS1 so that we can better understand adaptation at high altitude in the mountains. It would be wonderful to carry out collaborative work with our South American colleagues, for example, from the Altiplano region and doctors from the Tibetan plateau, the Himalayas and the Hindu Kush regions in South Asia. Ideally carrying out clinical and genetic research may not only shed light on the effects of hypoxia at high altitude but may also eventually help us in better managing hypoxic conditions such as chronic obstructive lung disease, and congestive heart failure at sea level.

Studies, especially randomized controlled trials of potentially useful drugs for the prevention and treatment of high altitude hypoxia-related illnesses, are plagued by small sample size that makes firm conclusions difficult. Perhaps with collaborative multi-center studies we can make some headway in rectifying the problem of small sample size. In addition with the changing demographics of unadapted people newly residing at high altitude (for example in the Tibetan plateau and also in the Khumbu region of Nepal with different, non-Sherpa ethnic groups living permanently in the high altitude areas), we may start to see increasing numbers of chronic mountain sickness. Finding ways of working together with South American colleagues who are experts in this field of chronic mountain sickness may also help foster useful, collaborative work.

In addition proper data collection in a systematic way from the high altitude regions of the world needs to be encouraged. The data collection needs to include not only chronic mountain sickness and the classic altitude sickness comprising of acute mountain sickness, high altitude cerebral edema, and high altitude pulmonary edema but also non-altitude sickness related problems at altitude. These include common neurological problems at altitude such as transient ischemic attacks, vision impairments, high altitude cough, and so forth. But this systematic collection of data is easier said than done. Although I have been the medical director of the Himalayan Rescue Association for many years, we have not collected important patient data. This is clearly a missed opportunity, and I am partly to blame for this.

Crucially we have to re-ignite the interest of the older members (even as we try to recruit newer members) so that members continue to pay their dues. We have to make it as easy as possible for people to pay as nothing is more exasperating than trying to pay your dues and experiencing technical difficulties. In addition we need to excite the young mountain medicine doctors and other health care professionals so that they can effectively play an active role in the

Society now and lead it into the future. Mountains have a romantic appeal for many people, and we need to exploit this love for the mountains so that health professionals go to the mountains for fun, for volunteering to work in organizations like the Himalayan Rescue Association, to participate in mountain medicine diploma courses, and so on.

A word about our meeting. This meeting with proper organization has the potential of fulfilling an important niche in mountain medicine. On the one hand, the prestigious, hypoxia meeting in Lake Louise, Canada, has increasingly become a very intellectual gathering with emphasis almost exclusively on basic science with speakers of Nobel Prize winning caliber. On the other hand, organizations like the WMS, who are passionately involved with mountain medicine, have international meetings emphasizing a practical, hands-on approach with topics like hundred uses of the safety pin in the wilderness. Clearly there is a middle ground focused on mountain medicine that is heretofore largely untapped. The next ISMM meeting in Bolzano, Italy in 2014 will showcase how our meetings can attempt to fill this void.

In closing, here is a subject close to my heart. Since time immemorial great numbers of pilgrims have ascended to sacred mountains and lakes at very high altitudes as a completely focused group of people totally unaware of the dangers. For example, at these sacred sites many of these pilgrims to Kailash Manasarovar area (5000 m) in Tibet, Amarnath (3900 m) in India, and Gosainkunda (4300 m), and Muktinath (4000 m) in Nepal seem to be totally ignorant about the life-threatening risks of altitude sickness. With the help of mountain medicine health professionals in China, India, and Nepal, we need to work together and focus attention on this vulnerable group to increase awareness about altitude sickness so that unnecessary morbidity and death is prevented.

In conclusion I hope that during my tenure as President we can primarily reenergize our Society so that we can vigorously move forward with our safety and useful data collection agenda including the ones outlined above. Your thoughts and suggestions are most welcome. My heartfelt thanks from the Himalayas for giving me this privilege to serve you as your president.