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# **CONSENSUS STATEMENT OF THE UIAA MEDICAL COMMISSION**

## **VOL: 2**

### **Emergency Field Management of Acute Mountain Sickness, High Altitude Pulmonary Edema, and High Altitude Cerebral Edema**

Intended for Doctors, Interested Non-medical Persons  
and Trekking or Expedition Operators

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## **Content**

1	Introduction.....	3
2	Risk situations for AMS, HAPE, and HACE.....	3
3	Clinical features.....	4
3.1	Typical symptoms of AMS.....	5
3.1.1	Scoring systems.....	5
3.2	Typical symptoms of HAPE.....	5
3.3	Typical symptoms of HACE.....	6
4	Treatment.....	6
4.1	Emergency management of AMS.....	6
4.1.1	Light to moderate symptoms.....	6
4.1.2	Severe symptoms.....	7
4.2	Emergency treatment of HAPE.....	7
4.3	Emergency treatment of HACE.....	8
4.4	Emergency treatment of combined HAPE and severe AMS.....	8
4.5	Emergency treatment of unclear situations.....	9
5	APPENDIX 1:.....	15
6	APPENDIX 2:.....	16
7	References.....	18

## **1 Introduction**

Acute mountain sickness (AMS), high altitude pulmonary edema (HAPE) and high altitude cerebral edema (HACE) are the most important and most common altitude-related diseases. Up to altitudes of about 5000-6000m, symptoms of altitude illness are a direct result of inadequate acclimatization. Dependent on the ascent profile, up to >70% of mountaineers may suffer from symptoms of AMS. Primary prevention is therefore considered the gold standard to avoid altitude illness. This includes a conservative ascent profile, adequate hydration and energy intake, and early recognition and management of potential medical problems, both before and during the trip.

This recommendation focuses on:

1. Situations where prevention has failed or other factors contributed to the development of AMS, HACE or HAPE (weather, rescue missions, predisposition etc) and;
2. On adult mountaineers (for children see UIAA Standard No. 9 [1])

**Note 1:** Since many trekking organizations do not follow an adequate altitude/time profiles [2], [1] prevention starts before booking! Check carefully the profile of your tour!

**Note 2:** An “adequate altitude/time profile” is defined in section 3 below.

## **2 Risk situations for AMS, HAPE, and HACE**

### **2.1 Risk factors**

- Inadequate altitude profile / ignorance of the needs of acclimatization
- Rapid ascent to high altitude
  - E.g.: airport of destination at high altitude, ascent by vehicle or undertaking an “aggressive” altitude profile while hiking. **Note:** The high camps of several expedition routes are situated within ~1000m of altitude difference. Here “yo-yo” tactics” (no overnight stay for the first ascent(s) to these camps) is recommended.
  - Team blocked at high altitude
  - “Re-entry problems” of people living at high altitude after visiting sea level for several days or weeks
- Previous History of AMS, HACE or HAPE
- Victim ignoring early symptoms of altitude illness
- Dehydration
- Elderly people (>65 years) showed a 3-fold higher risk for HAPE [3]. No such risk was found for AMS and HACE.

## 2.2 Altitudes and time frames

- Typical altitudes at risk:
  - >ca. 2,500 m for AMS
  - >ca. 3,000 m for HAPE
  - >ca.4,000 – 5,000 m for HACE
  - **Note:** symptoms lower than the altitudes mentioned are rare, but even severe cases are possible!
- Typical time frame for symptoms
  - AMS: >4 hrs and <24 hrs after ascent to new altitude
  - HAPE (& HACE): >24 hrs
  - **Note:** Onset of AMS-symptoms <4 or >24 hrs, or HAPE-symptoms <24 hrs is rare, but possible!

## 3 Prevention of altitude diseases

- Acclimatize properly!
  - Above 2500-3000m the next night should not be planned more than 300-500m higher than the previous one
  - Have two nights at the same altitude after every 2-4 days of ascent. On this day you may climb higher, but return to sleep.
  - The use of drugs to prevent altitude symptoms should be restricted to some special situations, especially if a fast ascent cannot be avoided for any reason (airport of destination at high altitude, rescue operations) or when a person suffers from symptoms although he/she has followed an adequate altitude profile (so called “slow acclimatizer”). For several reasons, especially cost-effectiveness-risk-ratios, acetazolamide is recommended. Mostly 500 mg/day has been recommended, but the dose-responsiveness is limited and 250-750 mg/day has been proven to be nearly equally effective [4], [5], [6], [7], [8].

## 4 Clinical features

**Note:** Since all members of a team had a similar or even identical ascent profile there may be more persons suffering from altitude disease than the one in whom you made the actual diagnosis. Never forget the porters and guides: Nowadays most of them are lowlanders and may suffer from altitude diseases at least as much than the tourists or climbers do [9], [2]!

#### 4.1 Typical symptoms of AMS

- Several of the following symptoms:
  - Headache (most often diffuse and non-localized, but other types of headache do not exclude AMS)
  - Sleep disorders
  - Loss of appetite
  - Dizziness
  - Listlessness
  - Peripheral oedema
  - Severe heart palpitation
  - Nausea or vomiting
- **Note:** Typical symptoms may not all be present, in a few cases even headache may be missing
- **Note:** In case of severe listlessness or somnolence: consider HACE! (see below)
- **Note:** Dyspnoea at light workload or even at rest: consider HAPE!

##### 4.1.1 Scoring systems

The **Lake Louise Symptom Score** (see Appendix 1) was primarily established to quantify the severity of AMS for scientific purposes (field studies). It may also be used for diagnostic purposes, but for field management of AMS the symptoms listed above and the consequences described below and in Appendix 2 are sufficient.

**Note:** AMS is a clinical diagnosis and should not be based on any scoring system only. Such systems may be used to quantify the severity of AMS.

#### 4.2 Typical symptoms of HAPE

- Dyspnoea even at light workloads progressing to dyspnoea at rest
  - High breathing rate (>30/min. in 69% of the cases [10])
- Rapid decrease in performance (cardinal symptom!)
- Cough
- High pulse rate
- Chest tightness
- Bubbling breath, cyanosis and bloody/foamy expectoration in severe cases
- Mild fever

### 4.3 Typical symptoms of HACE

- Severe headache without response to usual painkillers
- Nausea and vomiting
- Dizziness
- Ataxia
  - **Note:** The heel-to-toe walking test is a very sensitive and simple field test which also helps to differentiate unclear situations (e.g. if people want to mask their symptoms)
- Altered consciousness, confusion or hallucinations
  - Irrational behaviour may indicate an early stage!
- Final stage: coma and death by respiratory paralysis
- Frequently there is loss of insight, by the patient, who may insist that they are all right and just wish to be left alone.

**Note:** Lay persons should always treat mountaineers for AMS, HAPE, HACE first, except if they are absolute sure that there is another reason for the symptoms. Doctors should also always consider AMS, HAPE, or HACE at (high) altitude first, but they should always take other diagnoses into account, especially those listed in the following tables.

**Note:** If it should be impossible for lay persons to decide whether a patient suffers from HAPE or HACE he should be treated for both.

## 5 Treatment

See also flow chart in appendix 2

### 5.1 Emergency management of AMS

#### 5.1.1 Light to moderate symptoms

- Stay at the same altitude (rest day) until symptoms have completely disappeared
    - No further ascent with symptoms!
  - Avoid any workload, especially with forced respiration during expulsion
  - Treat symptomatically (oral therapy)
    - Nausea: antiemetics (e.g. dimenhydrinate)
    - Headache: paracetamol or ibuprofene (no acetyl salicylic acid (aspirin)) because of increased risk for bleeding and gastric ulcer)
    - Acetazolamide 250mg (2x/day) may be considered if the above fail after 6-12 hours. **Note:** This drug is not considered to be a first line treatment of AMS anymore.
  - Try to drink enough in spite of nausea
  - Descend if symptoms do not improve or worsen within 24 hours
  - Sleep with slightly elevated upper body
-

### **5.1.2 Severe symptoms**

- Exclude HACE!
  - If there should be any doubt: Treat as HACE!
- Rest immediately, never continue ascent!
  - Protect patient against cold
- Treat symptomatically as described above
- Dexamethasone 8 mg
  - May be repeated after 6 hrs, if symptoms should be still severe
- Descent as soon as possible to the last camp or hut, where the patient was well (or at least about 500 (– 1,000) meters)
  - “As soon as possible” means, that the symptoms were significantly ameliorated before and the patient will be able to manage the terrain (distance, steepness...) safely
  - The patient shouldn't carry loads while descending
  - Do not leave the camp to descend if there are ascents en route.
    - With severe symptoms the patient may be unable to manage even short ascents, even if they are short.
  - If possible, do not descent completely, otherwise there wouldn't be any stimulus for acclimatization anymore
- If a portable hyperbaric chamber is available, refer to UIAA recommendation No.3 [11]
- No re-ascent before the patient feels completely well.

### **5.2 Emergency treatment of HAPE**

(see also flow chart in appendix 2)

- Rest immediately, never continue ascent!
  - Upper body in upright position
  - Protect patient against cold
- Oxygen (if available)
- Nifedipine slow release, 20 mg
  - Onset of the effect after 10 – 15 min.
  - Repeat, if symptoms should worsen again
    - No time frame possible! Pure clinical decision based on symptoms.
  - Avoid using nifedipine short release! This may cause a severe decrease of blood pressure.
- Portable hyperbaric chamber
  - For use and tactics refer to UIAA recommendation No.3 [11]
- PEEP valve, if patient accepts it
- Leave high altitude

- Passive transport, where available (stretcher, helicopter etc)
- Where passive transport is impossible descent as soon as the treatment decreases symptoms.
  - Take equipment down to continue therapy en route if necessary
  - The patient should never carry any load
  - see also remarks on descending with HACE (see below)

**Note:** Do not use diuretics (e.g. furosemide as recommended in the past for treatment)!

Note: A couple of NO donors have shown to be effective, too (e.g. Sildenafil [12], [13] or Tadalafil [14], [15]). But UIAA MedCom does not recommend them as first line drugs for the following reasons:

1. Data were obtained from small collectives and sufficient clinical field studies are missing.
2. Side effects (massive headache in 15% of users may interfere with AMS symptoms)
3. The costs are about 100x higher than the well established Nifedipin s.l..

### **5.3 Emergency treatment of HACE**

(see also flow chart in appendix 2)

- The management is the same as for HAPE but instead of Nifedipine give Dexamethasone as follows:
  - Dexamethasone
    - If the patient is conscious they should be given 8 mg orally every 6 hours until they are free of symptoms
    - In severe cases a parenteral initial dose of 8-10 mg (depending on size of ampoule dose) should be given either i.v. or i.m.
    - In extremes in adverse weather conditions this parenteral dose may have to be given i.m. through clothing to a moribund patient and under these circumstances higher initial doses have been tried. Preloaded ready to use syringes can be easier to handle and use in these adverse conditions
    - It is also possible to drink the ampoule's content
- Additional acetazolamide 250mg bid may be an additional benefit
- While descending, pay more attention to the patient's safety, especially in any case of dizziness or ataxia!

### **5.4 Emergency treatment of combined HAPE and severe AMS**

- Manage as for both HAPE and HACE.



### **5.5 Emergency treatment of unclear situations**

Sometimes there may be patients where the diagnosis of “pure” AMS, HAPE, or HACE is unclear. This may happen if lay persons have to make the diagnosis, but also for physicians some situations, e.g. with severe AMS/HACE but moderate HAPE. Here typical symptoms of HAPE may be masked by the predominating symptoms of AMS/HACE. Here UIAA MedCom recommends treating as for both, AMS/HACE and HAPE

**Most important differential diagnoses in AMS and HACE**

<b>Diagnosis</b>	<b>Patient's history</b>	<b>Symptoms</b>	<b>Therapy</b>	<b>Remarks</b>
<b>Exhaustion</b>	Previous intense activity?	Impaired fitness, lack of motivation, impaired mood, headache. Severe cases: collapse.	Rest, refuel with carbohydrates, fluid, and cold protection. Severe cases: glucose i.v., passive transport	Eating complex carbohydrates are preferred to carbohydrates with a high glycaemic index to prevent the risk of hypoglycaemia occurring during treatment!
<b>Dehydration</b>	Hot climate, inadequate fluid intake, diarrhoea, vomiting	Thirst, lack of motivation, impaired mood, impaired fitness, headache, oliguria, dry skin and mouth, fever. Severe cases: tachycardia, collapse dizziness, delirium, seizures; urine colour often dark yellow	Rest and rehydrate! Slight hypotonic beverages are best. Severe cases: glucose 5%, potassium lactate, or NaCl 0.9% i.v. (at least 1000 ml, continued by oral rehydration)	Restoring a normal hydrated status may need several days! Lack of thirst does not indicate adequate hydration at altitude! Drink even when you don't feel thirsty! The colour of urine does not indicate adequate or inadequate fluid balance (but urine volume of at least 1 l/day does)
<b>Sunstroke</b>	Exposure to intensive sunlight?	Meningitis-like headache, fatigue, dizziness, nausea, vomiting, tachycardia. Final stage: stupor, coma.	The victim should take no further activity. Place him in the shade or inside a room. Drink plentiful cool fluids. Take a painkiller.	Monitor the patient, situation may be life-threatening!
<b>Heat stroke</b>	Hot climate, inadequate fluid intake, lack of fitness combined with physical activity	Similar to dehydration, but with neurological symptoms and collapse, respiratory arrest and circulatory collapse. Hot skin	Rest in shade, cool patient, apply fluid to his/her clothing to increase evaporation, survey breathing and circulation. Passive transport.	Life-threatening situation! Allow time for appropriate heat adaptation before demanding activities are started!
<b>Hangover</b>	Previous intake of alcohol of any kind of wine / liquor?	Diffuse, non-localized headache, fatigue, nausea, lack of motivation	Give oral non-alcoholic fluid – if possible with electrolytes – or just wait.  Survey patient!	Do not allow the patient to belay or to, lead. He won't make good decisions!  <b>Note:</b> Be warned that recent reports suggest excessive drinking is occurring more frequently in mountain huts.

Other (rarer) differential diagnoses

Diagnosis	Patient's history	Symptoms	Therapy	Remarks
<b>Seizures</b>	Ask about previous seizures! If patient is unconscious, comrades may be able to give information.	Localized or generalized attacks with sudden onset, sometimes aura or postictal semi-conscious state	Protect the patient from falls first, especially in the mountains! Diazepam rectally or i.v. in severe cases.	First seizure at altitude is an extreme rare event!
<b>CO intoxication</b>	Cooking or fuel powered lights inside of the tent or a snow cave	Headache, confusion.	Oxygen (if available) or fresh air (open tent or cave!)	<b>Note:</b> No cyanosis!
<b>Acute psychosis</b>	Psychic or psychiatric history?	Complete loss of control of acceptable behaviour, resulting in extraordinary risk for the patient and possibly other group members in the mountains.	Sedative or antipsychotic drugs in severe cases. <b>Note:</b> some drugs may impair breathing, especially if used at altitude!	First episode of a psychiatric disease at altitude in patients without any psychiatric history is an extreme rare event!
<b>Stroke (TIA / progressive stroke)</b>	In most cases no special history	More or less sudden onset of paresis, speech impediments, and other neurological symptoms	In regions with some infrastructure (e.g. Alps): Passive transport to hospital as soon as possible.  On some expeditions passive transport is not appropriate, but most cases recover within 24-48 hours. In any case: monitor patient, stabilize blood pressure in case it becomes >200/100 mmHg	Potentially life-threatening situation!
<b>Brain tumour</b>	In most cases no special history	More or less sudden onset of paresis, speech impediments, and other neurological symptoms. Normally misinterpreted as stroke / TIA (see above)	Cortisone i.v. (high dosage). Stabilize blood pressure in case it becomes >200/100 mmHg. Monitor patient. Passive transport to hospital as soon as possible.	If no history of tumor / metastases is known, this diagnosis is almost impossible to make in the field.

(cont. next page)

Other (rarer) differential diagnoses (cont.)

Diagnosis	Patient's history	Symptoms	Therapy	Remarks
<b>Hypoglycaemia</b>	Diabetes?  <b>Note:</b> Specific risk for diabetic mountaineers: Acetazolamide (contraindication for diabetic patients!)	Hunger, nausea / vomiting, tachycardia, restlessness / tremor, sweat, impaired fitness, lack of motivation, impaired mood, dizziness, mydriasis, hypertension	Rest and feed complex carbohydrates (oligosaccharides). Measure blood glucose concentration every 15 min. until patient is fine and concentration is stable >60 mg/dl (>3.3 mmol/l).	Significant hypoglycaemia without diabetes is a very rare event and normally not induced by physical activity!
<b>Diabetic ketoacidosis</b>	Only in diabetic patients. With modern therapy rare, but possible if the diabetic problem is combined with fluid loss (e.g. traveller's diarrhoea or high altitude dehydration). <b>Note:</b> Specific risk for diabetic mountaineers: Acetazolamide (contraindication for diabetic patients!)	First signs similar to Dehydration (see there). Severe cases: tachycardia, hypotension, oligo-anuria, hyperglycaemia	Potentially life-threatening situation! Monitor patient continuously! Rehydrate patient (NaCl 0.9% i.v., 1000 ml 1 <sup>st</sup> hour, continued according to symptoms). Rapid acting insulin "low dose scheme" (20 E i.v. as bolus, followed by 5 – 10 E/hr i.v.) until blood glucose concentration is <250 mg/dl (<13.9 mmol/l).  Transport to hospital as soon as possible.	Devices to measure blood glucose concentration give false-low results if used at <14°C (<0°C no measurement possible).  <b>Note:</b> bicarbonate administration in the wilderness without lab results is very risky! It may induce extreme hypokalaemia
<b>Hyponatraemia</b>	Intake of high amounts of salt-free beverages (water, tea...), normally in hot climate or in cases of traveller's diarrhoea.	Impaired fitness, lack of motivation, impaired mood, dizziness, syncope, collapse.  Salt stained clothing or sweat stings eyes.	Rest. Give oral rehydration solution, or beverages with a small pinch of salt. If severe, administer hypertonic mannitol, i.v. hypertonic NaCl 3% at rate 1-2 ml/kg/hr.	Allow time for appropriate heat adaptation before demanding activities will be started! Do not drink excessive quantities of water or plain tea.
<b>Meningitis / Encephalitis</b>	No special history in most cases (contact with persons who had similar symptoms some days ago?)	Massive, meningitis-like headache, fatigue, dizziness, nausea, vomiting, tachycardia, fever. Final stage: stupor, coma.	Antibiotics, painkillers. Take care for your safety and that of the group's - the patient should wear a mask! Transport to hospital as soon as possible.	Survey patient! <b>Note:</b> situation may be life-threatening!
<b>Intoxication / drug abuse</b>	Intake of any drug or plant?	Several neurological / psychiatric symptoms, depending on the drug used.	Monitor patient (circulation, breathing). Cold protection.	Treatment with specific drugs is normally not realistic in the mountains.

Most important differential diagnoses in HAPE [16]

Diagnosis	Patient's history	Symptoms	Therapy	Remarks
"Physiological dyspnoea"	High altitude exposure	Tachypnoea without any other symptom	none	--
Altitude cough ("Khumbu cough")	Exhaustive work at high altitude or in very cold environment	(Very) severe dry cough which may cause pain (chest, trachea, throat), no fever	Antitussive drugs, throat lozenges. <b>Note:</b> Most antitussive drugs contain codeine (respiratoric depressor), but that should be no problem if normal dosage is used (e.g. 5 mg / ½ tabl. dihydrocodeine). Alternatively use noscapin 25 mg	Only relief is by descent to low altitude
Hyperventilation syndrome	Agitation, massive fright	Tachypnoea, often combined with tingling sensations of the extremities, dizziness, sometimes collapse / unconsciousness	Calming down the patient, breathing controlled by counting seconds. Normally no drug therapy necessary	Self limiting after collapse. Most important danger: injuries caused by fall.
Sleep apnea	High altitude exposure	Phases of dyspnoea or apnoea at night	Improve acclimatization. If symptoms persist, try theophylline 300 – 400 mg slow release or acetazolamide 250mg in the evening <b>Note:</b> theophylline slow release is not available in some countries	--
Cardiac insufficiency	Coronary heart disease / myocardial infarction? Cardial insufficiency / valvular heart disease	Dyspnoea, moist rales, pathologic cardiac sound (S3)	Furosemide 40 – 80 mg i.v.	--
Pulmonary embolism (/deep vein thrombosis, DVT)	Dehydration, immobilization (flight!) varicosis, contraception pills, factor V leiden	Dyspnea, tachycardia, splitted 2 <sup>nd</sup> cardiac sound, one-sided swollen leg possible	Heparin 25,000 I.E., if available	Most important non-traumatic risk for fatal incidences at high altitude!
Pneumonia	Infection, fever, cough, expectoration	Cough, expectoration, chills, one-sided pulmonary rales	Antibiotics (macrolides or tetracycline)	Fever does not exclude HAPE from pneumonia!

Other (rarer) differential diagnoses to HAPE [16]

Diagnosis	Patient's history	Symptoms	Therapy	Remarks
<b>Asthma</b>	Strain / stress? Infection? Aspirin (10% of attacks are caused by aspirin!)? Cold air?	Ronchus, dry rales, expiratoric dyspnea	Betamimetics (aerosols with aerochamber or i.v.), corticoides i.v., theophylline (i.v. or klysm), in extreme situations ketamine narcosis	First asthma episode at altitude is a very rare event! Ask for history of asthma!
<b>CO intoxication</b>	Cooking or fuel powered lights inside of the tent or a snow cave	Headache, confusion.	Oxygen (if available) or fresh air (open tent or cave!)	<b>Note:</b> No cyanosis!
<b>CO<sub>2</sub> narcosis</b>	Very tightly closed tent or snow cave	Sluggishness, somnolence, dyspnea	Oxygen (if available) or fresh air (open tent or cave!)	--
<b>Pneumothorax</b>	Spontaneous or traumatic	Acute dyspnea, one-sided reduced or missing respiratory sounds	Puncture / drainage (severe cases only)	--
<b>Neurogenic pulmonary oedema</b>	High altitude exposure, unsuccessful therapy of HAPE	Symptoms of HACE, sings for intracranial pressure, pulmonary oedema	Massive therapy of the HACE (high dosages of corticoide and oxygen!)	--
<b>Drug induced pulmonary oedema</b>	Heroine? Cocaine (mountaineering in the Andes!)?	Heroine: Miosis; Cocaine: Mydriasis (of both pupillae)	Diuretics, no nifedipine!	--
<b>Aspirin induced pulmonary oedema</b>	Headache and aspirin intake	Typical pulmonary oedema	Cortisone, diuretics, no nifedipine!	--

Of course, there are some other rare diagnoses (e.g. pertussis) [16].

**6 APPENDIX 1:**

**Lake Louise Symptom Score (LLSS) self-report-questionnaire for adults [17], [18], [19]**

<b>Symptoms</b>	<b>Severity</b>	<b>Points</b>
Headache	- no headache	0
	- mild headache	1
	- moderate headache	2
	- severe headache, incapacitating	3
Gastrointestinal	- no gastrointestinal symptoms	0
	- poor appetite or nausea	1
	- moderate nausea or vomiting	2
	- severe nausea or vomiting, incapacitating	3
Fatigue and / or weakness	- not tired or weak	0
	- mild fatigue/weakness	1
	- moderate fatigue/weakness	2
	- severe fatigue/weakness, incapacitating	3
Dizziness / lightheadedness	- not dizzy	0
	- mild dizziness	1
	- moderate dizziness	2
	- severe dizziness, incapacitating	3
Difficulty of sleeping	- slept as well as usual	0
	- did not sleep as well as usual	1
	- woke up many times, poor night's sleep	2
	- unable to sleep	3

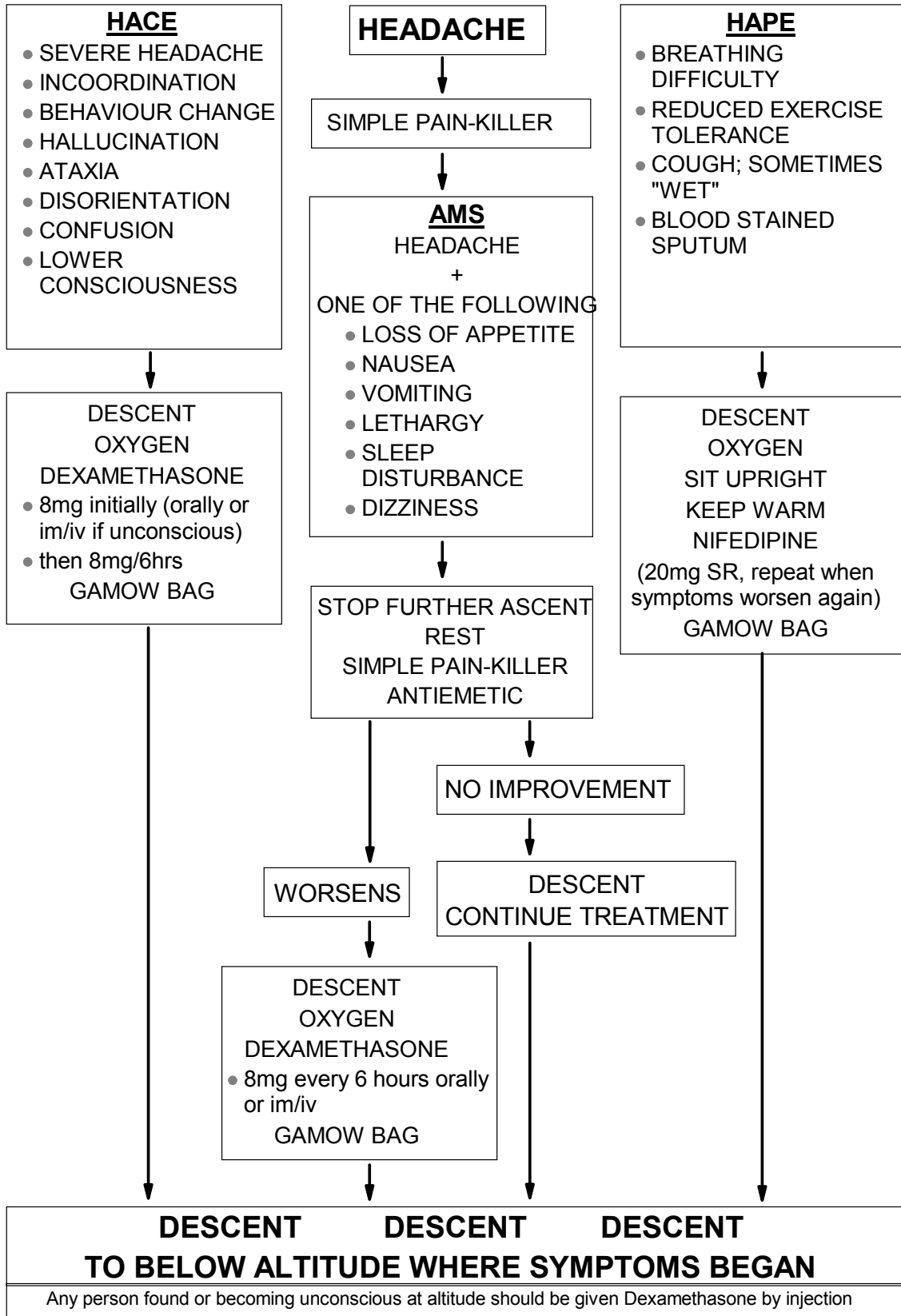
**A total of > 3 points indicates AMS** (if no evidence for other reason of symptoms)

**Note:** For scoring systems for children see UIAA Consensus Paper No.9 "Children at Altitude" [1]

**7 APPENDIX 2:**

**AMS is a serious medical condition which can quickly lead to HACE which is a life threatening emergency. Any signs or symptoms should be reported to expedition leader. All symptoms at altitude must be considered as altitude related until proven otherwise.**





## **8 References**

1. Meijer, HJ and D Jean. *Consensus Statement of the UIAA Medical Commission Vol.9: Children at Altitude*. 2008 [cited 2008 11.1.09]; Available from: [www.theuiaa.org/medical\\_advice.html](http://www.theuiaa.org/medical_advice.html).
2. Kupper, T, D Hillebrandt, and N Mason, *Medical and Commercial Ethics in Altitude Trekking*. High Alt Med Biol, 2012. **13**(1): p. 1-2.
3. Gautret, P, et al., *Travel-associated illness in older adults (>60 y)*. J Travel Med, 2012. **19**(3): p. 169-77.
4. Kayser, B, et al., *Reappraisal of acetazolamide for the prevention of acute mountain sickness: a systematic review and meta-analysis*. High Alt Med Biol, 2012. **13**(2): p. 82-92.
5. Carlsten, C, ER Swenson, and S Ruoss, *A dose-response study of acetazolamide for acute mountain sickness prophylaxis in vacationing tourists at 12,000 feet (3630 m)*. High Alt Med Biol, 2004. **5**(1): p. 33-9.
6. Basnyat, B, et al., *Efficacy of low-dose acetazolamide (125 mg BID) for the prophylaxis of acute mountain sickness: a prospective, double-blind, randomized, placebo-controlled trial*. High Alt Med Biol, 2003. **4**(1): p. 45-52.
7. Porcelli, MJ and GM Gugelchuk, *A trek to the top: a review of acute mountain sickness*. J Am Osteopath Assoc, 1995. **95**(12): p. 718-20.
8. Basnyat, B, et al., *Acetazolamide 125 mg BD is not significantly different from 375 mg BD in the prevention of acute mountain sickness: the prophylactic acetazolamide dosage comparison for efficacy (PACE) trial*. High Alt Med Biol, 2006. **7**(1): p. 17-27.
9. Basnyat, B and JA Litch, *Medical problems of porters and trekkers in the Nepal Himalaya*. Wilderness Environ Med, 1997. **8**(2): p. 78-81.
10. Menon, ND, *High-Altitude Pulmonary Edema: a Clinical Study*. N Engl J Med, 1965. **273**: p. 66-73.
11. Kupper, T, U Gieseler, and J Milledge. *Consensus Statement of the UIAA Medical Commission Vol.3: Portable Hyperbaric Chambers*. 2008 [cited 2008; Available from: [www.theuiaa.org/medical\\_advice.html](http://www.theuiaa.org/medical_advice.html)].
12. Fagenholz, PJ, et al., *Treatment of high altitude pulmonary edema at 4240 m in Nepal*. High Alt Med Biol, 2007. **8**(2): p. 139-46.
13. Kleinsasser, A and A Loeckinger, *Are sildenafil and theophylline effective in the prevention of high-altitude pulmonary edema?* Med Hypotheses, 2002. **59**(2): p. 223-5.
14. Luks, AM and ER Swenson, *Medication and dosage considerations in the prophylaxis and treatment of high-altitude illness*. Chest, 2008. **133**(3): p. 744-55.
15. Maggiorini, M, et al., *Both tadalafil and dexamethasone may reduce the incidence of high-altitude pulmonary edema: a randomized trial*. Ann Intern Med, 2006. **145**(7): p. 497-506.
16. Goebbels, K, et al., *Cough and dyspnoea of an asthmatic patient at Mt. Kilimanjaro: a difficult differential diagnosis*. Travel Med Infect Dis, 2011. **8**(1): p. 22-8.
17. Hackett, P, *The Lake Louise Consensus on the definition and quantification of altitude illness*, in *Advances in the Biosciences Vol. 84: Hypoxia and mountain medicine, Proceedings of the 7th International Hypoxia Symposium, Lake Louise, Canada 1991*, Sutton, J, Coates, G, and Houston, C, Editors. 1992, Pergamon Press: Oxford. p. 327-330.
18. Roach, RC, et al. *The Lake Louise acute mountain sickness scoring system*. in *8th International Hypoxia Symposium*. 1993. Lake Louise: Queen Printers Inc.
19. Savourey, G, et al., *Evaluation of the Lake Louise acute mountain sickness scoring system in a hypobaric chamber*. Aviat Space Environ Med, 1995. **66**(10): p. 963-7.

## **9 Further reading**

- Travel at High Altitude (several languages, available at: [http://medex.org.uk//medex\\_book/about\\_book.php](http://medex.org.uk//medex_book/about_book.php))
- T. Küpper, K. Ebel, U. Gieseler: Moderne Berg- und Höhenmedizin, Gentner Verlag, Stuttgart, 2010, ISBN 978-3-87247-690-6

### **Members of UIAA MedCom (in alphabetical order)**

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### **History of this recommendation paper**

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