Extreme altitude transient aphasia

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Severe mountain sickness, cerebral oedema, or ischaemic infarcts may occur when humans ascend to high altitude. However, neurological symptoms can occasionally be atypical. Recently, we studied a highly experienced climber who had suffered difficulties in expressing himself verbally, emitting incomprehensible sounds during a strenuous ascent to 8000 m in the Himalayas. The speech disorder, which was not associated with other neurological impairments, disappeared following a short rest. Cranial magnetic resonance imaging, performed 40 days later, showed small high intensity signals in the posterior lobes. To our knowledge, the nearest neurological episode to this case is a self report by Shipton1 in 1943.

Cerebral blood flow is highly sensitive to changes in carbon dioxide tension. CO₂ inhalation increases brain perfusion quickly reversing many high-altitude neurologic disturbances. Hackett et al.2 reported six cases of altitude cortical blindness who showed excellent response to CO₂ administration. A severe fall in the arterial Pcco₂ (at rest approximately 10 mm Hg at 8000 m) due to intense pulmonary gas exchange during fast ascents to extreme altitude can result in non-uniform vasoconstriction and tissue distribution. This mechanism, together with an increased blood viscosity and coagulability in a high mountain environment, would increase the hypoxic insult, especially in small vessel territories of the brain.

Although the precise significance and future implications of these magnetic resonance findings are not clear, the presentation and clinical evolution of this case strongly suggest a selective vasospasm of brain speech areas. Nevertheless, these imaging findings may be related to cumulative cerebral damage, as we have observed in a large number of climbers after repeated exposure to extreme altitude.3 Indeed, the increasing popularity of attempting to conquer the world's highest summits without supplementary oxygen would lead us to conjecture that such autolimitmed neurological episodes occur more frequently than is reported in the mountain medicine literature.

1 Shipton EE. Upon that mountain. London: Hodder and Stoughton, 1943:129.

“"I was that child”

For several years I was involved in swimming, a sport that is vulnerable to those who wish to abuse children. On a typical training day parents take their children to the pool early in the morning. The swimmer strips, almost naked, and spends up to two hours in the water, supervised usually by only one adult. The whole process is repeated again that evening. The coach may see much more of the swimmer than the swimmer's parent. It is easy to understand how a swimmer could be dominated by their coach.

My own memories of these events are all too clear. My coach never allowed us to change in the changing rooms, insisting that we “derobe” on the side of the pool, whether or not we had our swimming trunks on before arriving at the pool. This was quite humiliating for those girls who had forgotten to put their bathing costumes on at home.

When my coach needed to give me a “ticking off”, he used never to approach me when I was fully clothed. He would wait until I was in my swimming trunks about to enter the water. Then and only then would he approach me. In this situation, the psychological advantages of clothes are immense. And the psychological abuse didn’t end there. If things were going poorly in competition or if I had done something to annoy my coach, I was purposely ignored for days on end. I remember I once acted in direct opposition to my coach and he ignored me for three months! To hurt me fur-
ther during those three months of silence, he openly and actively encouraged a rival swimmer, and team-mate, to try to beat me. During rest periods, he would shout encouragement to my rival, telling him how to improve, pointing out my weaknesses to him, never addressing me directly. I hated my "rival" because I thought he was stealing my coach away from me. It's embarrassing to admit but I was completely dependent on my coach and felt that I would never achieve anything without him.

At one point relationships were so strained because of these psychological mind games that on a four man relay team, which set a record, the backstroke swimmer refused to talk to the breaststroke swimmer; the breaststroke swimmer in turn wouldn't talk to the butterfly swimmer; and all three barely acknowledged the freestyle swimmer. There was genuine hate among swimmers who were supposed to be team-mates. As it turned out, this coach—while abusing me psychologically—was doing far worse to other members of my swimming team. They were sexually abused. My coach did try to abuse me once; I was 9 years of age and away from home. Fortunately I was uneasy and requested him to leave my bedroom.

I have over the last few years tried to contact some of my team-mates from my years in swimming. I am glad to say that the rival whom I detested is now a good friend. Other swimmers have suffered long term problems. I have read widely on the outcome of people who have been abused as children. I can recognise many of the symptoms in people I know.

Ironically, there are others who may have gained in some way from the experience. These persons have a high self esteem, and developed very strong characters. It's extraordinary to think that there could be an unexpected positive side to abuse, but I would count myself among this group. My dependency on my coach has changed and I now consider myself strongly independent. I have emerged from my swimming years, certainly with some regrets that I didn't form the friendships many in swimming deserved, but I have an appreciation for the risks involved in sporting situations.

So how can we prevent persons getting involved in sport that should never be allowed to take charge of children? It's difficult. By definition the typical abuser is the very person you would never suspect, they have to be the "trustworthy type". But you cannot legislate against people who are determined to abuse children. What you can do is make people more aware of the potential situations that lend themselves to abuse. Any in my opinion that is the essence of any preventive programme, addressed at ending child abuse in sport.

LETTERS TO THE EDITOR

EDITOR,— I was delighted to receive the BJSM in Bosnia, an improving journal.

I write to comment on the observational clinical test of Achilles tendon rupture reported by O'Brien.2

The diagnosis of Achilles tendon rupture is dependent on physical examination and symptoms of sudden pain and swelling over the posterior aspect of the tendon.1

O'Brien's test which consists of inserting a needle into the proximal tendon and looking for movement on attempting plantar flexion.

In my experience, the easiest way to assess the continuity of the Achilles tendon is to look at the angle at which both feet rest when the patient lies prone with both lower limbs from mid calf hanging over the end of a couch. The normal foot lies in some plantar flexion because of the intrinsic tone of the intact gastrocnemius-soleus complex. The affected foot hangs vertically, at 90 degrees to the couch. Thompson's test is then used to confirm the diagnosis. In the case of a rupture where the diagnosis has been delayed, the degree of loss of plantar flexion will provide the diagnosis, and the degree of shortening required if surgical intervention deemed necessary.

Finally, I would like to put forward the psoas tendon as a candidate for the title the thickest tendon in the body!

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Verbal encouragement of voluntary muscle action: reply to Commentary by Roger Eston

EDITOR,— Thank you for the opportunity to address Mr Eston's comments (Vol 30, no 3, page 245), particularly those relating to the statistical analysis of the data. The statistical procedures undertaken in this study were carefully matched to the Latin squares cross-over design. The procedures are detailed in Joseph Fleiss's book The design and analysis of clinical experiments.1 In respect to examining the effects of gender, in this instance a test of the difference of the pre and post values for the verbal and non-verbal conditions of males and females, provides no less information than using an ANOVA on pre and post values. If there had been more than two groups compared, ANOVA would be a more appropriate test.2

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BOOK REVIEWS

Quantum Strength and Power Training (Gaining the Winning Edge), By P O'Shea. (Pp 248; $20.00.) Patrick's Books, 1996. ISBN 0 948689 0 2.

There is perhaps no subject more underdeveloped in the area of sports performance than that of resistance training. Although there are many texts in this area, few, if any, address the fundamental issues of resistance training as they relate to sports performance (as opposed to general fitness). In this capacity alone the book is valuable. Dr O'Shea has combined his lifetime of practical and theoretical knowledge to skilfully write this text. Hence it is not surprising that it contains invaluable insights into many areas of resistance training for sports performance.

The book is inexpensive (it's a softback) and easy to read, and although I feel it has greater applicability for more advanced participants, the abundance of tables, photographs, and diagrams will make it attractive to the novice. I say the text may have more applicability for the advanced participant as it assumes a certain level of existing knowledge and contains little in the way of information about how to start a weight training programme.

The author might consider this in future revisions.

The text contains strong sections on power lifting and Olympic style lifting and does a decent job on anatomical and physiological considerations for resistance training. From an academic point of view I would like to see primary and direct referencing to support the