

metronidazole) per and post-operatively the patient remained in septic shock and died 12 h later.

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References

- ELLIS, H. (1982). *Intestinal Obstruction*, Appleton-Century-Crofts: New York.
- SHANKAR, S., BRADLEY, J.W.P. & PARKER, M. (1984). Gallstone perforation of the ileum without obstruction. *Postgraduate Medical Journal*, **60**, 696.
- VAN LANDINGHAM, S.B. & BRODERS, C.W. (1982). Gallstone ileus. *Surgical Clinics of North America*, **62**, 241.

Failure of acetazolamide to prevent acute mountain sickness

Sir,

I was the medical officer accompanying a recent trekking expedition to Nepal. As we were to ascend to 17,650 ft over the Thorong La, we acclimatized thoroughly, and all 14 members of the party took acetazolamide 250 mg b.d., commenced 3 d before climbing above 10,000 ft.

At around 9,500–10,000 ft, a very fit 19 year old female member of our party became unwell and sought medical attention. She had felt nauseated and dizzy getting up that morning (8,500 ft), but this feeling had partly disappeared and she managed to walk to 800 ft or so before lunch with little trouble. On starting off after lunch, during which she had felt sleepy, nauseated and anorexic, she became rapidly dyspnoeic in exertion, weak, dizzy and drowsy to such an extent that she would go off to sleep if left resting for more than five minutes.

Physical examination revealed an exhausted pale but not cyanosed individual, her chest clear to auscultation, and dextrostix excluded hypoglycaemia. She was also noted to be staggering occasionally. A diagnosis of altitude sickness was made and descent started.

Within 500 ft of descent there was an improvement in her condition and by the time the starting altitude of 8,500 ft was reached, she felt normal again, but had partial amnesia for events further up. The remaining member of the party crossed the pass and completed the trek with minimal problems due to altitude.

Acute mountain sickness has been reported at altitudes as low as 7,000 ft (Beeson & McDermott, 1979) and acetazolamide is known to be a useful prophylactic (Green *et al.*, 1981; Larson *et al.*, 1979) for the condition. However, it is not a panacea (Editorial, 1981), and this is emphasized by this girl, who despite taking acetazolamide developed marked altitude sickness at an altitude frequently reached both in Europe and the Himalayas. Immediate descent produced a rapid and sustained improvement in her physical condition.

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References

- BEESON, P.B. & McDERMOTT, W. (eds) (1979). *Textbook of Medicine* 15th edition, p. 101. W.B. Saunders: Philadelphia.
- EDITORIAL (1981). *British Medical Journal*, **283**, 396.
- GREENE, M.K., KERR, A.M., McINTOSH, I.B. & PRESCOTT, R.J. (1981). Acetazolamide in prevention of acute mountain sickness: a double blind crossover study. *British Medical Journal*, **283**, 811.
- LARSON, E.B., ROACH, R.C., SCHOENE, R.B. & HORNBEIN, T.F. (1982). Acute mountain sickness and acetazolamide: clinical efficacy and effect on ventilation. *Journal of the American Medical Association*, **248**, 328.