Letters to the Editor

Dysesthesias of the Hands and Feet After Visiting Lhasa, Tibet

To the Editor:

Unexplained foot pain and dysesthesias have been previously reported after expeditions to the Himalayas or Karakoram. In English language journals, there are few reports about this particular variety of neuropathic pain without any visible injury to the tissues, unrelated to known trauma, frostbite, or trench foot. Here we describe a case of a young female tourist who developed dysesthesias of her hands and feet after visiting Lhasa, Tibet, for a week.

A 23-year-old Venezuelan sea level native woman (born in Maracaibo, Venezuela, 2–8 m above sea level, 28°C average temperature), previously healthy and working and living in Shanghai (2–10 m above sea level, 3°C average winter temperature), China, visited Lhasa (3655 m above sea level, 1°C average winter temperature), Tibet (Xizang), as a tourist in February 2008. She arrived by train, having traveled approximately 3000 km over 51 hours. During the middle of the ascending trip (at approximately 3000 m above sea level), she developed headache, nausea, hyporexia, and hypoesthesia in her hands and feet. She had no visible skin changes or signs of trauma. She stayed in Lhasa for 1 week, and her symptoms worsened. The hypoesthesia increased in magnitude to the point at which she practically lost all sense of pain, temperature, and pressure. She also noted mild decreased urine output and mild constipation.

A day after she returned to Shanghai, her headache, nausea, and hyporexia resolved, but the mild oliguria, constipation, and paresthesias persisted for 5 days. At that time she sought medical attention from us. After evaluating her, we recommended acetaminophen, cold protection, and maintenance of good oral hydration. She was informed about the possible occurrence of such effects associated with the high- and moderate-altitude trips. She was followed for 11 days, during which her oliguria, constipation, and paresthesias disappeared completely.

Similar cases have been reported recently. One of these reports corresponded to a review of 12 mountain-climbers who were affected by a sensitivity loss in their toes without cutaneous evidence of frostbite. In that series, all patients had taken part in snow and ice climbs at high altitudes (2500–4808 m). All cases presented with a “corky” sensation and a reduction in touch and thermal sensitivity, as occurred in our case. Also similar to our case, there was no accompanying skin paleness, cyanosis, blisters, or pain. In those cases, the disorder resolved spontaneously in 1 to 3 months without sequelae, whereas our patient’s symptoms resolved in 11 days. The authors attributed this syndrome to the combined effect of cold, compression by crampon straps, and repeated microtrauma during snow and ice climbing, which could alter vascular flow to the toes and cause ischemic damage of the digital nerves. Ricart de Mesones et al and Jimeno et al proposed the term “resolutive temporal hypoesthesia” to describe this condition. Diagnosis in the field is based on clinical features. Specific diagnostic techniques for assessing small-caliber nerve fiber neuropathy would be required to confirm the diagnosis, because in these patients results of neurological physical examination are usually unrevealing.

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References