bility to HAPE after a sojourn at low altitude as brief as one or two days.[3] Some aspect of their long-term acclimatizations appears to be lost rapidly, rendering them vulnerable upon reascent to their home environment. It is true, as Marticorena and Hultgren[4] have reported recently, that high altitude natives in whom HAPE develops upon reascent can be treated effectively while remaining at high altitude with oxygen and rest, or perhaps even bed rest alone. However, such high altitude natives differ physiologically from unadapted lowlanders. I have observed trekkers with HAPE at 14,000 feet whose conditions did not improve with rest and supplemental oxygen for 48 hours, and in whom improvement occurred only when helicopter evacuation became available. Consequently, we should be cautious in extrapolating experience gained from high altitude natives when confronted with a lowlander with AMS. Prompt descent remains the most reliable form of treatment, and prevention the ultimate goal.

With ever-increasing numbers of visitors to the high altitude regions of the world, the medical problems of high altitudes will become more frequent and more familiar. We must consider not only those millions seeking recreation in the mountains, but also those persons who are taking up residence at high altitude for such industrial purposes as oil shale development, mining of molybdenum above 12,000 feet and construction of the Eisenhower tunnel at 11,300 feet under Loveland Pass in Colorado, as well as the families of such workers who populate communities like Leadville, Colorado, at 10,200 feet. From pregnant women to infants to the elderly with poor health, long-term residence at high altitude poses another set of medical problems which we are only beginning to appreciate, much less understand. The review by Hultgren in this issue is indeed timely.

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Lessons From Skull Films

THE BRIEF REPORT "Skull Radiography and Professional Liability" which appears elsewhere in this issue has obvious lessons which illustrate its title. A skull film reported as normal may not be, or it may be apparently normal but fail to disclose a significant abnormality that actually is present—with all the risks that this implies for both patient and physician. This is evident enough. But there are other lessons to be extracted from this simple report. For example, a less expensive procedure, such as making a roentgenogram of the skull, may not be as cost-effective as one that is more expensive, such as computerized tomography. This fact may make the use of less costly and less effective procedures unnecessary, or prevent delays in diagnosis which may in turn add, perhaps tragically, to the disability and the cost. In the cost conscious times we are in, there is need for more attention to actual cost benefits, as more sophisticated and more expensive techniques become available to practicing physicians. And another lesson is that perhaps it is time to review and update our thought processes in patient care, to question some of the stereotypes of practice (a skull film will reassure the patient and provide some legal protection for the physician) and to reexamine what we are doing and why we are doing it—particularly when science and technology make available new, though perhaps more expensive, approaches to medical care.

—MSMW

Implications of Successful Combination Chemotherapy for Testicular Germ Cell Neoplasms

ELSEWHERE IN THIS ISSUE Einhorn and Williams outline their chemotherapy results for recurrent and metastatic testicular germ cell neoplasms. Results of their trials[1] as well as those of others[2] have significantly altered the prognosis of patients with such tumors. It is important to place these advances in perspective and examine their implications in terms of the overall approach to germ cell neoplasms.