

High-altitude mountain telemedicine

Massimo Martinelli¹ , Davide Moroni¹, Luca Bastiani²,
Simona Mrakic-Spota², Guido Giardini^{3,4} and
Lorenza Pratali^{2,3,4}

Journal of Telemedicine and Telecare
2022, Vol. 28(2) 135–145
© The Author(s) 2020



Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/1357633X20921020
journals.sagepub.com/home/jtt



Abstract

Introduction: An innovative teleconsultation platform has been designed, developed and validated between summer 2017 and winter 2018, in five mountain huts and in three remote outpatient clinical centres of the Italian region Valle d'Aosta of the Mont Blanc massif area.

Methods: An ad-hoc videoconference system was developed within the framework of the e-Rés@MONT (Interreg ALCOTRA) European project, to tackle general health problems and high-altitude diseases (such as acute mountain sickness, high-altitude pulmonary and cerebral oedema). The system allows for contacting physicians at the main hospital in Aosta to perform a specific diagnosis and to give specific advice and therapy to the patients in an extreme environment out-hospital setting. At an altitude between 1500–3500 m, five trained nurses performed clinical evaluations (anamnesis, blood pressure, heart rate, oxygen saturation), electrocardiographic and echography monitoring on both tourists and residents as necessary; all of the collected data were sent to the physicians in Aosta.

Results: A total of 702 teleconsultation cases were performed: 333 dismissed (47%), 356 observed (51%) and 13 immediate interventions (2%). In 30 cases the physicians decided there was no need for helicopter and ambulance rescue intervention and hospital admissions. The main physiological measures, the classified pathologies, the severe cases and the cost savings are described in this article.

Discussion: The e-Rés@MONT teleconsultation platform has been discussed in terms of treated cases, feasibility, proactivity in reducing complexities, direct and indirect advantages, and diagnostics help; moreover, general and specific pros and cons have been debated, and future steps have been exposed.

Keywords

Teleconsultation, acute mountain sickness, healthcare, information and communication technology, telehealth

Date received: 20 November 2019; Date accepted: 31 March 2020

Introduction

Technology plays a vital role in further improving the healthcare sector. Digital technologies and the evolution in communication are changing the approach in the practice of medicine. Telemedicine has quietly become a part of healthcare and of everyday practice.¹

Recently, the potential for remote patient management through evolving technologies has increased patients monitoring as well as advice to physicians. In fact, a physician is now able to assist from a distance, and this is crucial in a mountain environment.^{1,2} Telemedicine offers a pragmatic, convenient and low-cost solution for high altitude and expedition medicine.^{3–6}

In order to improve healthcare for both tourists and residents in a mountain environment, and to manage

acute mountain sickness (AMS) and general health problems, an innovative teleconsultation system has been developed within the EU Interreg V-A ALCOTRA 2014–2020 e-Rés@MONT project (code 492, start date 31 August 2016, end date 1 March 2018).

¹Institute of Information Science and Technologies, National Research Council of Italy, Italy

²Institute of Clinical Physiology, National Research Council, Italy

³Mountain Medicine Centre, Valle d'Aosta Regional Hospital, Italy

⁴Montagne Sûre, Italy

Corresponding author:

Massimo Martinelli, Institute of Information Science and Technologies, National Research Council of Italy, Via G. Moruzzi 1, 56124 Pisa, Italy.
Email: massimo.martinelli@isti.cnr.it

Mainly, the aim of the e-Rés@MONT project was to design, develop, perform and experiment with an innovative healthcare service to support mountain populations. The development of this project not only helped people who live in mountain areas but also improved the attractiveness of such areas for tourists. A network of structures and professional operators was built around Mont Blanc (Italy, France and Switzerland). The e-Rés@MONT project ended on March 2018 and the project was realised in collaboration with a group of five nurses trained in emergency setting and mountain medicine before they started their activity.

A specific Web platform was designed and implemented to be accessible via tablet with a mobile connection, providing:

- A user friendly interface customised for the two groups of users, nurses and physicians;
- A multimedia text chat-audio-video real-time conference system, built on purpose for privacy reasons, allowing a connection with a medical doctor in a remote hospital;
- Methods for storing images and videos for clinical evaluation;
- A tool for the risk assessment of acute diseases which was accessible via Web and via a mobile application (app), based on a modified version of the National Early Warning Score (NEWS)⁷ adapted in order to monitor oxygen saturation (SaO₂) and blood pressure (BP) at different altitudes;
- A survey for individual lifestyles;
- An automatic evaluation of AMS based on the Lake Louise Score (LLS)⁸ version 1993;
- An automatic evaluation of high altitude pulmonary edema (HAPE) and high altitude cerebral Edema (HACE)⁹;
- An automatic evaluation for severity Glasgow Coma Scale (GCS) to measure the consciousness of the patients.¹⁰

When the Internet connection was unavailable, a decision support system (DSS) app on a tablet provided the nurses with the risk scores necessary to assess the severity of the patient and allowing them to decide whether to call the emergency system directly. Once the Internet connection was restored, all data recorded and saved locally were automatically sent to the hospital.

At the hospital, the physicians on duty checked all of the data and, if necessary, they would require a video consultation with the nurse and the patient. Once the diagnosis was made it would be stored within the platform and sent to the nurse who in turn would have to confirm the reading and communicate it to the patient.

A healthcare model, the first of this kind in Europe to our knowledge, based on a telecooperation and

virtual teleconsultation service in mountain environment has therefore been developed and employed with both the locals and the people who spend time in a mountain environment episodically (tourists, hikers, climbers, etc.).

This model of teleconsultation is uncommon, at least in Italy; as a matter of fact, the Italian Law (12 July 2012) defined the goals of telemedicine: secondary prevention, diagnosis, care, rehabilitation and monitoring, rules are transferred to future integrations. In the meantime, the Italian Autonomous Region of Valle d'Aosta, in concordance with the Italian Government defined their guidelines for the use of telemedicine.

Methods

A platform of teleconsultation was designed and developed by the Institute of Information Science and Technologies (ISTI) in collaboration with the Institute of Clinical Physiology (IFC) part of the National Research Council (CNR) of Italy. The platform allowed to access a Web system (Figure 1(a)), via a tablet equipped with a mobile 3G/4G connection. The trained nurses from remote mountain huts in the Italian Northern mountain area, at an altitude between 1533–3500 m, were enabled to send multimedia data (physiological parameters: blood pressure (BP), heart rate (HR), SaO₂; electrocardiogram (ECG) and echography) to the hospital in Aosta where a doctor would make a diagnosis.

This platform provided an ad-hoc videoconference system built using the most recent technologies with auto-adapting video-band. When the connection was unavailable, a DSS, in the form of an offline Web app, provided scores and suggestions to the nurses which allowed them to evaluate the clinical severity, to dispense emergency aids and to call rescue services when needed. When the connection become available again, the locally stored data were sent to the hospital. Based on the acquired information, the presence of AMS was also automatically assessed. Doctors and nurses chose the validated scales, readjusted physiological parameters according to the altitude, defined tools and drugs, and identified a protocol to follow. As for symptoms, the patients were submitted to clinical evaluation (i.e. vital parameters, SaO₂, body mass index (BMI), LLS questionnaire for AMS scoring); moreover, a five or 12-lead ECG and lung ultrasound could be performed. Based on the data received, the doctor on call would make the medical decisions, and nurse(s) who provided care to the patient(s) would receive the appropriate instructions.

All the subjects needing evaluation for AMS or any other symptoms were submitted to a standardised clinical evaluation: anamnesis, state of consciousness, BP,

(a) Login page:

Teleconsultation

Login

User:

Password:

Location:

(b) Medical devices measures page:

HAPE diagnosis:

Medical devices measures

Systolic blood pressure:

Diastolic blood pressure:

Heart rate:

Oxymetry:

Respiratory rate:

Body temperature:

Supplementary oxygen:

Awareness state:

HAPE score:

Severity:

Monitoring frequency:

NEWS score clinical response:

e-Rés@mont adapted to NEWS score:

Glycaemia:

Body weight kg:

Altezza cm:

5-lead ECG: No file selected.

12-lead ECG: No file selected.

Ecography: No file selected.

Photo/Video: No file selected.

Note:

Figure 1. The login page of the e-Rés@MONT teleconsultation Web system (a) and the medical devices measures page (b). ECG: electrocardiogram; HAPE: high altitude pulmonary edema; NEWS: National Early Warning Score.

HR, respiratory rate (RR), body temperature and SaO_2 monitoring. When necessary, the nurses would also perform ECG monitoring and ultrasound examination with a portable appliance.

Figure 1(b) shows the Web page dedicated to the collection of parameters obtained through medical devices for the teleconsultation.

The NEWS was used to determine the disease level of severity in patients and to solicit critical care intervention. In this study, the NEWS was adapted on the basis of the altitude therefore the SaO_2 and systolic blood pressure (SBP) parameters were normalised.¹¹ The system, depending on the NEWS, can classify the subjects based on colour codes for disease levels of severity: white stands for mild diseases, yellow for medium-severity diseases that need a medical consultation in a short time, red for a level of severity that requires a direct call to the emergency system by phone (European emergency number 112).

In case of a yellow code and the simultaneous lack of Internet connection, the nurses should check the patient again within half an hour for a new clinical evaluation.

Figure 2 shows the teleconsultation list page accessible to the physicians: an immediate visual comprehension of the situation utilising the severity codes is presented, offering the possibility to search by single or multiple fields and globally on all the collected data.

Cutting-edge Web technologies were adopted: users had to open a browser (e.g. Firefox or Chrome) from a tablet and access a Web page. Behind the Web page there was a persistence module deputy with the aim to handle all the data, a logic module, also including the

DSS providing risk scores and suggestions, a signalling module which can put in contact the nurse tablet with the physician tables (on activation, the connection continued peer to peer, without intermediary).

The videoconference data-rate was auto-adapted depending on the Internet band. The system is developed at Pisa, by a team from CNR-ISTI, as a prototype, and is connected to the Internet backbone (server) via cable.

In each mountain hut involved in this study, there were tablets equipped with a subscriber identity module (SIM) card, or a satellite connection with a wi-fi router providing a local area connection.

The final system has been deployed in the hospital and connected via cable to the Internet. In the Aosta hospital, a router was programmed to provide a secure connection for the tablet of the physicians (Figure 3).

To build our ad-hoc videoconference, Web Real-Time Communications (WebRTC)¹² was adopted, an open source project created to enable secure real-time communication of audio, video and data in Web and native apps (Figure 4). It had multiple application programming interfaces (APIs) related to capturing, recording and streaming audio and video, and also for streaming data between users. It is usable through a recent browser (i.e. Firefox or Chrome) on desktop and mobile apps.

For storing data locally in the offline teleconsultation app, Localstorage¹³ was used, a technology providing new methods to store information securely and locally in a browser. It has bandwidth, speed and security advantages compared to the old cookies

	IdVisit	Motivat	Severit	Sistolic	Diastol	Glicemi	Cardiac Frequer	Location	Saturat	Respirat Frequer	body temper.	visit date	Login	Diagno	Date diagnos	Med	Id
Show	772	nausea and headache. High diastolic value	1	120	90		76	LaThuileCT	96	16	35.8	2018-02-27 11:49:36.4		Ipertension	2018-02-26 09:48:24.7		
Show	771	check-up	1	116	70		78	RifugioTor	92	16	36.0	2018-02-25 10:43:03.4		Asintomat	2018-03-06 10:38:41.7		
Show	770	check-up	2	143	73		95	RifugioTor	92	16	36.0	2018-02-25 10:34:55.4		Asintomat	2018-02-25 12:19:11.5		
Show	769	feeling of fever	0	158	84		83	RifugioTeo	92	18	36.7	2018-02-25 08:51:09.1		Asthenia	2018-02-25 10:27:43.1		
Show	768	check-up	1	132	77			RifugioTor	94	12	36.0	2018-02-24 17:59:47.3		Asintomat	2018-02-25 12:19:23.1		
Show	767	check-up	2	130	60		105	RifugioTor	95	12	36.0	2018-02-24 17:50:12.4		Nausea	2018-03-06 10:38:58.8		
Show	766	check-up	3	108	69		94	RifugioTeo	89	18	35.5	2018-02-24 16:09:10.1		Cardiopati	2018-02-24 16:14:38.0		
Show	765	check-up	1	134	70		100	RifugioTeo	86	18	36.5	2018-02-24 16:04:18.7		Asintomat	2018-02-24 16:12:59.5		
Show	764	check-up	0	151	93		85	RifugioTeo	120	18	37.7	2018-02-24 15:58:47.9		Fever	2018-02-24 16:11:50.6		
Show	763	check-up	0	121	56		83	RifugioTeo	86	18	36.8	2018-02-24 15:54:12.9		Asthma	2018-02-24 16:17:28.8		
Show	762	check-up	5	141	76		95	RifugioTeo	85	18	34.3	2018-02-24 15:46:04.7		Nausea	2018-02-24 16:11:29.7		
Show	761	check-up	0	130	72		79	RifugioTeo	94		36.6	2018-02-24 15:40:34.1		Asintomat	2018-02-24 16:15:15.5		
Visualizza	760	check-up	3	125	63		64	RifugioTeo	92	18	34.7	2018-02-23 15:01:15.7		Ipertension	2018-02-23 16:04:18.6		

Figure 2. The teleconsultation list page.

technology, providing even more space. Moreover, information stored using local storage cannot be accessed from a different host.

For sending data between the remote mountain huts and the hospital, Websocket¹⁴ was used, a new full-duplex communication protocol that can remain permanently active, enabling the exchange of information between the client and the server.

Results

Between summer 2017 and winter 2018, 702 teleconsultations were performed with the Aosta hospital within five mountain huts and in one remote outpatient clinical centre with the Aosta Hospital (males 61%; females 39%; average age 49 ± 17 years).

The system performed the functions designed for mountain areas adequately: all data were correctly received at the hospital and teleconsultations allowed the specialists to check all the measurements in order to give their advice and to decide the final diagnosis and treatment. Figure 5 shows the teleconsultations by age

groups: distribution is almost normal, although no sample selection was made.

In Table 1 the primary measures of age in years, SBP and diastolic blood pressure (DBP), HR, RR beats per min (bpm) and the SaO_2 , grouped by location, altitude and gender are reported.

As expected, SaO_2 decreased as altitude rose, while the mean age, BP and HR were lower in females. Moreover, in Cogne the average age was higher, probably because the healthcare centre supplies the entire local population in addition to the tourists.

Out of 702 consultations, a total of 203 resulted in an identified pathology (Figure 6): the most frequent pathologies were AMS (8.0%), headache (4.0%), minor trauma (2.3%), (which represented the 70% of the entire pathologies) and gastrointestinal disorders (1.3%).

In Figure 7 the macro-categories of pathologies have been grouped by the mountain huts. The total percentage of AMS was 15.25%. As expected, AMS diagnosis increased at higher altitudes, but some differences have to be acknowledged: at the Mantova mountain hut (3498 m) the AMS percentage was lower if compared

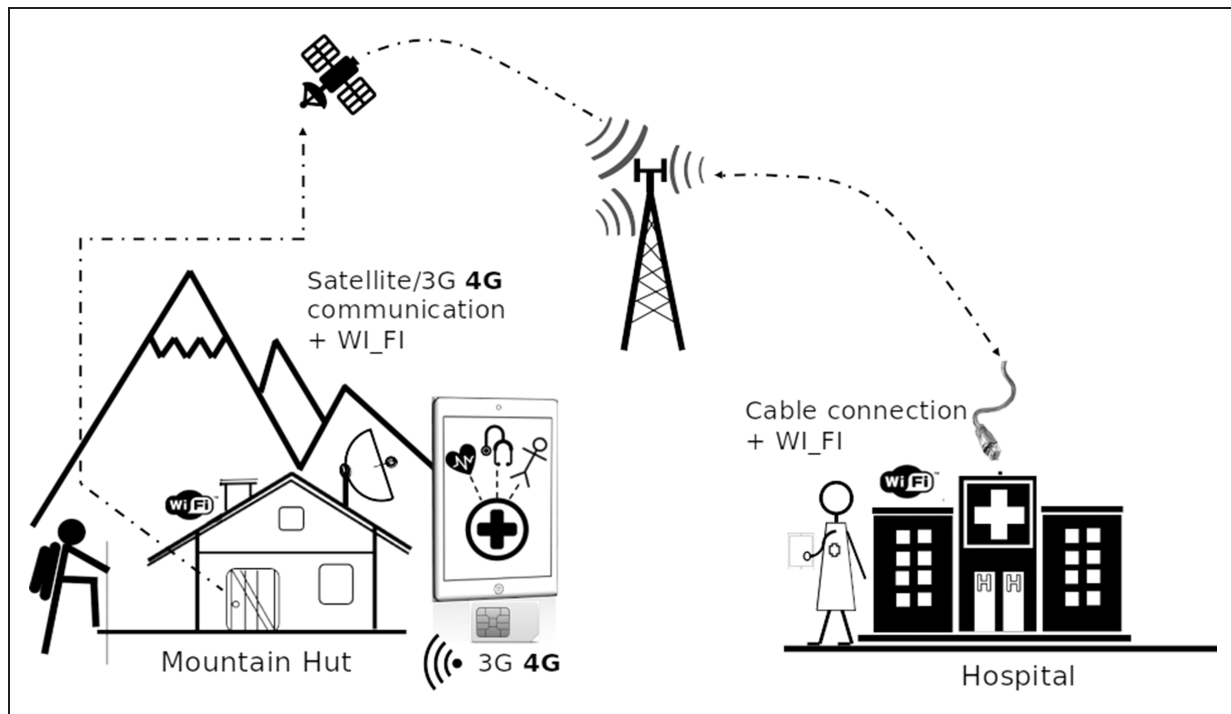


Figure 3. Connections schema.



Figure 4. An example of a videoconference test via Web Real-Time Communications (WebRTC) between the Institute of Information Science and Technologies (ISTI)-National Research Council (CNR) headquarters in Pisa and one of the participating mountain huts.

with the others at similar altitude: Teodulo (3317 m) and Torino (3375 m) huts.

On the contrary, at the Torino and Teodulo mountain huts the AMS diagnosis was higher (41% and 26.5% respectively).

The teleconsultation system allowed us to reach a final diagnosis and treatment decision with an average time of 32 min. The subjects evaluated by the system were classified as 333 white codes (47%), 356 yellow codes (51%) and 13 red codes (2%).^{15,16}

Figure 8 shows the distribution of the severity codes grouped by sites: mountain huts at high altitude and wherever the patients' average age was higher, and red codes were common.

Figure 9 shows the macro-categories of all the pathologies: red and yellow codes versus red codes only (13 red, 17 yellow).

In all sites where the e-Rés@MONT teleconsultation was used the AMS represented the most common pathology (58.2%) if we take into account together red and yellow code cases and even more if we consider only the red code cases (69.2%).

Specifically, the diagnoses labelled as red code cases were:

- AMS macro-category: severe AMS, vertigo, headache, syncope;

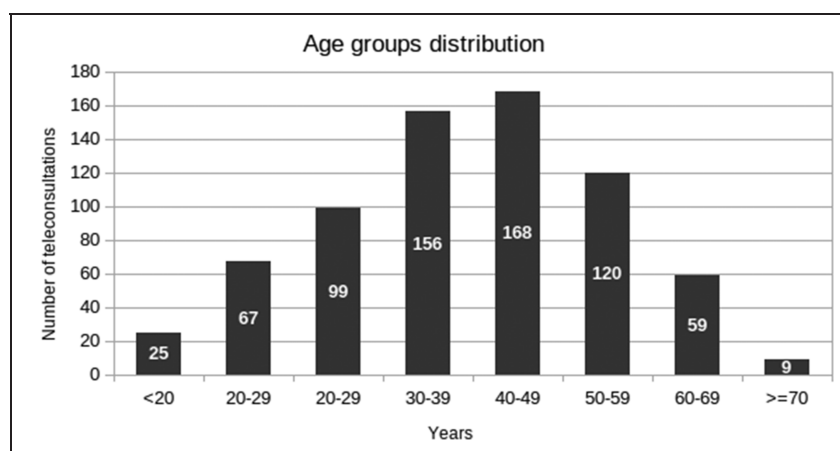


Figure 5. Age groups and distribution of teleconsultations.

Table 1. Main physiological measures grouped by location, altitude and gender.

Height above mean sea level (altitude)	Gender	Age (years) Mean (SD)	Systolic pressure (mm Hg) Mean (SD)	Diastolic pressure (mm Hg) Mean (SD)	Heart rate (bpm) Mean (SD)	Respiratory rate (mean per min) Mean (SD)	Oxygen saturation (SaO ₂) Mean (SD)
Cogne centre 1396	Female	61.5 (18.7)	130.8 (19.5)	74.8 (11.0)	77.2 (11.7)	16.4 (1.5)	96.6 (1.5)
	Male	54.8 (18.0)	133.8 (14.5)	76.4 (8.8)	73.2 (11.4)	16.5 (1.6)	96.6 (1.3)
Col de la Seigne hut 2365	Female	45.7 (14.4)	119.7^a (13.6)	75.2^a (9.2)	83.0 (12.8)	14.8 (2.2)	94.5^a (2.0)
	Male	46.4 (17.5)	127.5^a (16.1)	79.2^a (10.7)	82.1 (13.0)	14.3 (2.1)	93.4^a (2.1)
Arbolle hut 2507	Female	51.4 (14.5)	117.9^a (18.1)	70.1^a (10.8)	77.4^a (12.5)	16.7 (1.3)	94.1 (1.7)
	Male	51.8 (15.7)	127.4^a (16.4)	78.1^a (12.5)	84.0^a (16.7)	16.7 (1.5)	94.3 (1.9)
Teodulo hut 3317	Female	37.1 (12.0)	118.4^a (17.7)	68.8^a (7.3)	83.8 (18.5)	14.8 (2.6)	93.6 (1.9)
	Male	45.0 (11.3)	132.9^a (15.8)	74.2^a (9.4)	82.2 (12.4)	15.7 (2.8)	92.3 (5.5)
Torino hut 3375	Female	45.9 (14.9)	126.2^a (21.7)	75.4 ^a (13.2)	79.5 (11.5)	16.8 (1.9)	91.0 (3.0)
	Male	44.6 (16.4)	136.2^a (17.8)	79.7 ^a (12.7)	81.4 (14.3)	17.1 (2.0)	89.9 (5.0)
Mantova hut 3498	Female	36.2^a (13.60)	118.1^a (12.5)	67.7^a (7.2)	84.3 (14.3)	15.5^a (2.1)	90.8 (1.7)
	Male	49.6^a (13.7)	129.2^a (17.8)	72.5^a (9.1)	80.9 (16.2)	17.0^a (2.0)	90.8 (3.2)

SD: standard deviation.

^ap-value<0.05, independent t-test.

- Chronic pathologies macro-category: hypertensive crisis;
- Acute conditions macro-category: hypotension and trauma.

In these 30 cases (yellow and red), the physicians on call in Aosta hospital decided to treat the patient on the spot and in most cases subjects were treated and then taken to a lower altitude as soon as possible on foot. As matter of fact, 30 inappropriate rescue interventions

were avoided: 18 ambulance trips and 12 helicopter flights, and consequently the related admittance to emergency and specialised hospital departments were avoided too. On the basis of these data the global savings achieved amounted to 75,489€ as detailed in Table 2.

Moreover there were other direct savings for the additional cost for hospital department and indirect savings for leaving helicopters, ambulances, structures and personnel free where needed, reducing traffic and pollution.

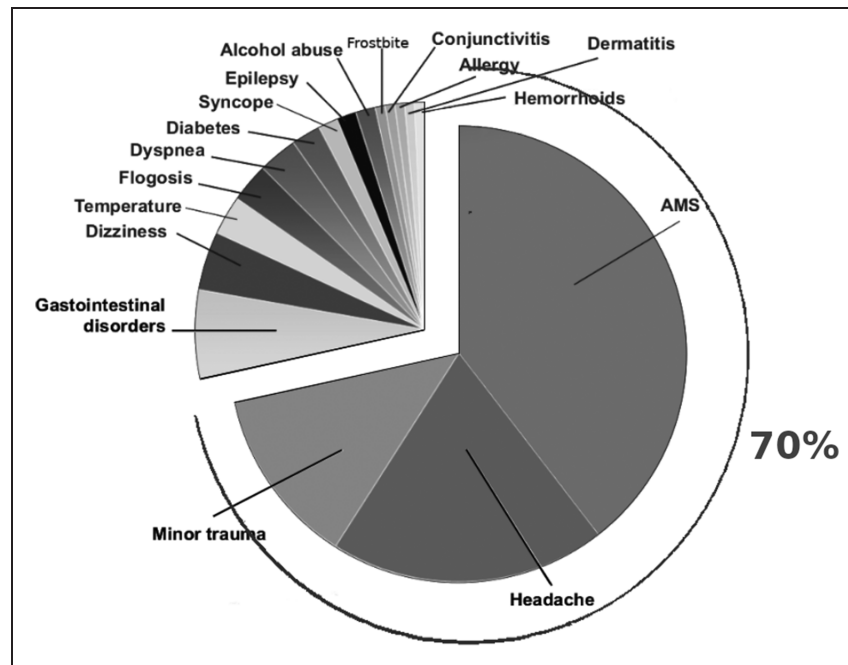


Figure 6. Classified pathologies in the e-Rés@MONT project. AMS: acute mountain sickness.

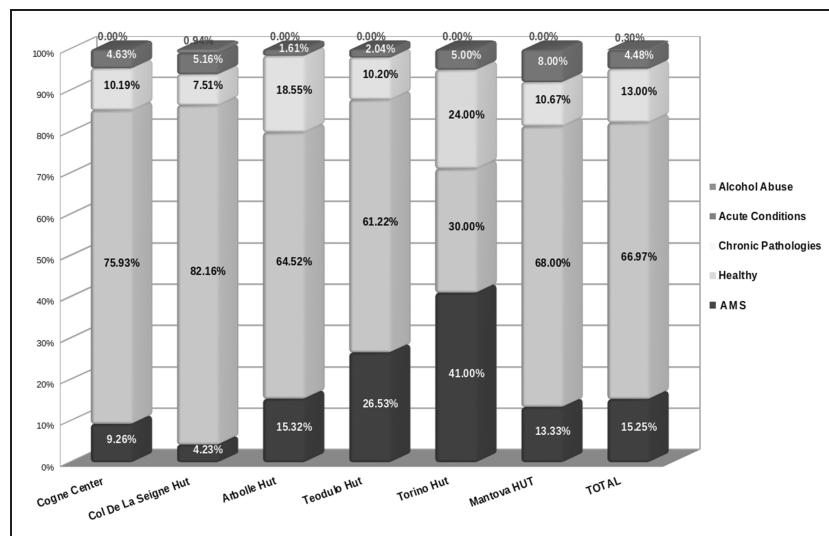


Figure 7. Macro-categories of pathologies: grouped by mountain hut and total. AMS: acute mountain sickness.

Discussion

While on the mountains and rural areas of other parts of the world, such as the Himalayas and other regions,^{19–21} telemedicine has spread non-sporadically in the last few years, on the European Alps telemedicine is still not common and, in Italy, it is not even fully regulated and practicable, apart from provinces and regions with special status. In this scenario, the teleconsultation platform proposed in this paper has been the first of this kind on the Alps, tackling AMS

and general health problems of both tourists and residents.

Technology plays a crucial role in the further development of the patient-centred healthcare,²² and the e-Rés@MONT platform can help to shorten the distance between patients and medical staff, and improve the timeliness of monitoring, diagnosis and treatment.

Examinations of 702 persons were collected and analysed, partly automatically and partly verified by physicians and by specialists when needed, through

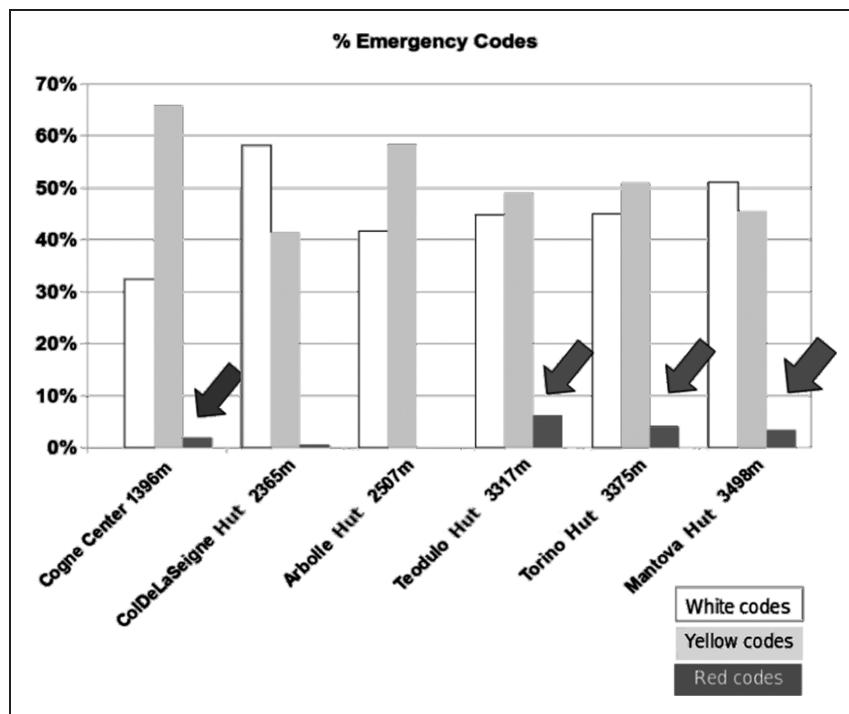


Figure 8. Emergency codes by location.

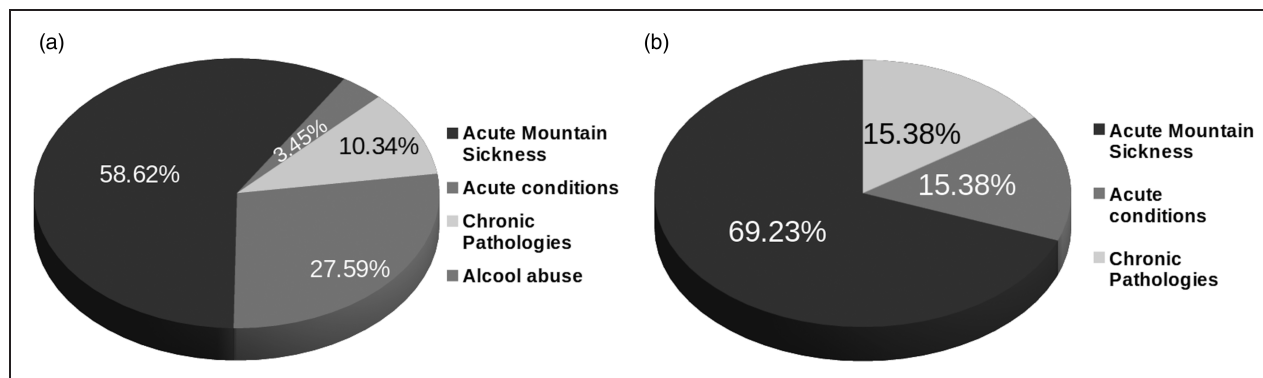


Figure 9. Macro-categories of pathologies for the 30 most severe cases: (a) red and yellow codes; (b) red codes.

Table 2. Global savings achieved.

Voice	Costs (€)	Cost function	Details
Avoiding helicopters call: direct saving	43,200	12*30*120	12 Flights; 30 min hypothetical average duration of a helicopter intervention; 120 €/min is the cost of a helicopter flight without a nurse or a physician.
Emergency treatment	7230	30*241	30 Cases evaluated. 241€ Is the average cost for emergency department treatment in the Regione Autonoma Della Valle D'Aosta. ¹⁷
Inappropriate use of helicopter rescue service	20,400	800*8 + 3500*4	800€ For 8 Italian citizens, up to 3500€ for 4 foreigners ¹⁸ to be paid to the Mountain Rescue service.
Supplement ticket for non local resident	4659	$\frac{(120*30*11+241*29)*10}{100}$	10% Extra charge for non resident fee applied by the regional health system: 29 non-resident, 1 resident red code.
Total	75,489		

the teleconsultation model proposed by the e-Rés@MONT project. The proposed platform has offered many advantages, not only the direct economic one (saving about 75,500€), which is certainly noteworthy but also the indirect ones. The advantages can be listed as (a) reduction of the waiting list (decision on treatment taking an average time of 32 min), (b) monitoring of multiple different pathologies (203 cases resulted in an identified pathology), (c) performing patient follow up, (d) opportunities for checking daily parameters in acute and chronic diseases, (e) providing teleconsultation everywhere, also from the doctors home, therefore reducing car traffic and, thus, the carbon footprint. With the results of the e-Rés@MONT teleconsultation system, it was possible to prevent deterioration in the different emergencies. Based on the physiological parameters measured, a score risk for the acute diseases was built up: the subjects that were diagnosed as a moderate risk were invited to rest and their follow-up was always performed.

Regarding the cons of the system: barriers remain in adopting these new technologies^{23–25} and it is essential to acknowledge that physicians actually prefer a face-to-face contact with patients²⁶ when they need to perform a clinical evaluation. However, often not all consultations require a complete physical examination. Moreover, in this project, the teleconsultation was carried on by expert nurses who had also been trained to use ultrasound devices. From the perspectives of information and communication technology (ICT), one of the possible significant problems of this teleconsultation system regarded connectivity, especially in the extreme and challenging environment where the project was meant to operate. An offline app with a clinical DSS was provided with the aim to reduce the need for a connection to solve relevant potential issues and, in the case of a red code case, the nurses should call the emergency system as soon as possible. Privacy was dealt with by encrypting any exchange of information and any sensitive information in the database. Rights to access the stored information were customised by group of users and by location.

From an economic point of view, initial costs for acquiring devices and training the medical staff could be influential, but operatively cost will be adequately recouped.

Correct diagnosis and treatment are defined as quality of care: telemedicine helps to provide the two main dimensions of quality of care, that are access and effectiveness.²⁷

The e-Rés@MONT platform also allowed staff to make an AMS diagnosis and to give to the subjects the right indication whether to keep staying at high altitude or to descend. In the results, as expected, the number of AMS cases increased at higher altitudes, but at the

Mantova mountain hut, the AMS diagnosis percentage was lower compared to other mountain huts at a similar altitude (the Torino and Teodulo mountain huts). These results could be associated with the fact that mountaineers at the Mantova mountain hut were generally more expert and to get the refuge they took the cableway up to 2980 m and afterwards they walked up to the Mantova mountain hut (3498 m). It is well-known that a slow ascent avoiding as much as possible mechanical transportation to climb a mountain is considered more appropriate for AMS prevention.²⁸ Appropriate preventive strategies should be adopted, i.e. warnings of acute high altitude disease risk should be visible at the starting point of the cable car, and should be useful in particular for tourists that decide to spend a night at high altitude without previous acclimatization.

Conclusions

The e-Rés@MONT multiparametric platform has been feasible and less time-consuming compared to the usual emergency system in a mountain environment. It can be self-financing with a low-cost sanitary ticket: a hypothesis provided by the Valle d'Aosta Region would be of about 35€.

With appropriate training, the platform could be used by the staff of the mountain huts without nurses or by the mountaineers themselves while staying in a bivouac, thanks to the video contact between doctors and subjects/patients. The e-Rés@MONT telemedicine platform can also be used for medical tourism, not only to improve healthcare in a challenging environment but also to save patients from the hassles of identifying and connecting with an appropriate health services provider, while removing language and cultural barriers.²⁹

Further studies are needed to assess the impact on health costs on waiting lists. Moreover innovative machine learning techniques can be used to classify diseases.³⁰ Non-availability of emergency healthcare services in mountainous, isolated and sparsely populated regions is a universal problem.³¹ In this regard, on 26 October 2017, a teleconsultation between rescue point in Pheriche (फेरिचे), a village in the Khumbu region of eastern Nepal, situated at an altitude of about 4371 m, and Pisa, Italy, was made using the e-Rés@MONT platform. A male Sherpa, 50 years old, was diagnosed with a case of acute respiratory insufficiency: the clinical evaluation was performed in about 30 min and all of the data were shared through the platform.

Finally, we can say that the e-Rés@MONT telemedicine platform could also be used in other situations, for example disaster relief, emergency situations³² and high altitude expeditions, because of its ease of use,

flexibility, adoption of innovative technologies, API applications and, above all, because it is within everyone's reach thanks to mobile apps. Furthermore, the proposal platform may form a guide to practice in the field of high-altitude telemedicine.

Acknowledgements

The authors would like to thank Solange Bonin, Marina Cugnetto, Andrea Fiorini, Niccolò Pernechele, Marco Ranfone, Laura Caligiana, Franz de la Pierre, Massimo Stella (Mountain Medicine Centre, Valle d'Aosta Regional Hospital, Italy), Jean P Fosson (Montagne Sûre, Courmayeur, Italy) and Thaneshwar Bhandari, Kamal Thapa, Buddha Basnyat for testing the platform (from Nepal), the partners of the project: Ifremmont, Hesso, Grimm, and Suwas Bhandari, Viviana Guglielmi, Roger Tonetti (Montagne Sûre, Courmayeur, Italy), Diego La Monica and Ovidio Salvetti (Institute of Information Science and Technologies, National Research Council of Italy) for their valuable contributions and suggestions.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest concerning the research, authorship and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was partially supported by the Interreg ALCOTRA EU 2014-2020 project e-Rés@MONT 'Applications de médecine de montagne autour du Mont-Blanc – Applicazioni di medicina di montagna attorno al Monte Bianco'.

ORCID iD

Massimo Martinelli  <https://orcid.org/0000-0001-7419-5099>

References

1. Szawarski P and Hillebrandt D. Doctor won't see you now: Changing paradigms in mountain medicine. *Postgrad Med J* 2018; 94: 182–184.
2. Ganapathy K, Alagappan D, Rajakumar H, et al. Tele-emergency services in the Himalayas. *Telemed J E Health* 2019; 25: 380–390. DOI: 10.1089/tmj.2018.0027.
3. Saffle JR, Edelman L, Theurer L et al. Telemedicine evaluation of acute burns is accurate and cost-effective. *J Trauma* 2009; 67(2): 358–365. DOI: 10.1097/TA.0b013e3181ae9b02.
4. Russo JE, McCool RR and Davies L. VA telemedicine: An analysis of cost and time savings. *Telemed J E Health* 2016; 22: 209–215.
5. Kvedar J, Coye MJ and Everett W. Early evidence, future promise of connected health connected health: A review of technologies and strategies to improve patient care with telemedicine and telehealth. *Health Aff (Millwood)* 2014; 33: 194–199.
6. Dinesen B, Nonnecke B, Lindeman D, et al. Personalized telehealth in the future: A global research agenda. *J Med Internet Res* 2016; 18: e53.
7. Royal College of Physicians. *National early warning score (NEWS) – standardising the assessment of acute-illness severity in the NHS*. London: Royal College of Physicians, 2012.
8. Roach C, Batsch P, Hackett PH, et al. The Lake Louise acute mountain sickness scoring system. In: JR Sutton, CS Houston and G Coates (eds) *Hypoxia and molecular medicine: Proceedings of the 8th International Hypoxia Symposium*. Burlington: Queen City Printers, 1993, pp.272–274.
9. Hackett P and Oelz O. The Lake Louise consensus on the quantification of altitude illness. Hypoxia and mountain medicine. In: JR Sutton, G Coates and CS Houston (eds) *Hypoxia and mountain medicine*. Burlington: Queen City Printers, 1992, pp.327–330.
10. Teasdale G and Jennett B. Assessment of coma and impaired consciousness. A practical scale. *Lancet* 1974; 2: 81–84.
11. Hackett PH and Roach RC. High-altitude medicine. In: Auerbach PS. *Wilderness medicine*. 3rd ed. St Louis, MO: Mosby, 1995, pp.1–37.
12. W3C® (MIT, ERCIM, Keio, Beihang). WebRTC 1.0: Real-time communication between browsers. W3C candidate recommendation, <https://www.w3.org/TR/webrtc/> (2019, accessed 20 January 2020).
13. W3C® (MIT, ERCIM, Keio, Beihang). Web Storage (second edition). W3C recommendation, <https://www.w3.org/TR/webstorage/> (2016, accessed 20 January 2020).
14. HTML - Living Standard. 9.3 Web sockets, <https://html.spec.whatwg.org/multipage/web-sockets.html> (2020, accessed 18 April 2020).
15. Palma E, Antonaci D, Coli A, et al. Analysis of emergency medical services triage and dispatch errors by registered nurses in Italy. *J Emerg Nurs* 2014; 40: 476–483.
16. Kent DM and Hayward RA. Limitations of applying summary results of clinical trials to individual patients: The need for risk stratification. *JAMA* 2007; 298: 1209–1212.
17. Autonomous Region of Valle d'Aosta. Resolution n. 1054, 4 August 2016, https://trekking.it/wp-content/uploads/2018/04/2016_1054_dgr.pdf (2016, accessed 20 January 2020).
18. Elisoccorso illesi, 184 mila euro in 2017-Agenzia Nazionale Stampa Associata, https://www.ansa.it/valle-daosta/notizie/2018/09/29/elisoccorso-illesi184-mila-euro-in-2017_f8fa725a-a62b-4386-b37c-d4bb5794e695.html (2018, accessed 18 April 2020).
19. Ganapathy K, Chawdhry V, Premanand S, et al. Telemedicine in the Himalayas: Operational challenges—a preliminary report. *Telemed J E Health* 2016; 22: 821–835.
20. Ganapathy K, Kanwar V, Bhatnagar T et al. mHealth: Awareness, perception and attitude of healthcare providers in Himachal Pradesh, North India. *Telemed J E Health* 2016; 22: 675–688.

21. Toit M, Malau-Aduli B, Vangaveti V, et al. Use of telehealth in the management of non-critical emergencies in rural or remote emergency departments: A systematic review. *J Telemed Telecare* 2019; 25: 3–16.
22. Aghdam MR, Vodovnik A, Hameed RA. Role of telemedicine in multidisciplinary team meetings. *J Pathol Inform* 2019; 10: 35.
23. Kruse CS, Karem P, Shifflett K, et al. Evaluating barriers to adopting telemedicine worldwide: A systematic review. *J Telemed Telecare* 2018; 1: 4–12.
24. Duchesne JC, Kyle A, Simmons J, et al. Impact of telemedicine upon rural trauma care. *J Trauma Injury Infection Crit Care* 2008; 64: 92–98.
25. Andres E, Talha S, Hajjam M, et al. Telemedicine: An underused weapon in the therapeutic arsenal of chronic heart failure. *J Clin Med Ther* 2018; 3: 3.
26. Patsis L. Toward a discourse community for telemedicine: A domain analytic view of published scholarship, https://digitalcommons.liu.edu/post_fultext_dis/2 (2017, accessed 18 April 2020).
27. Bynum AB and Irwin CA. Evaluation of the effect of consultant characteristics on telemedicine diagnosis and treatment. *Int J Telemed Appl* 2011; 2011: 701089. DOI: 10.1155/2011/701089.
28. Bärtsch P and Swenson ER. Acute high-altitude illnesses. *N Engl J Med* 2013; 369: 1666–1667.
29. Hong Y. Medical tourism and telemedicine: A new frontier of an old business. *J Med Internet Res* 2016; 18: e115.
30. LeCun Y, Bengio Y and Hinton G. Deep learning. *Nature* 2015; 521: 436.
31. Ganapathy K, Alagappan D, Rajakumar H, et al. Tele-emergency services in the Himalayas. *Telemed J E Health* 2019; 25: 380–390.
32. Smith AC, Thomas E, Snoswell CL, et al. Telehealth for global emergencies: Implications for coronavirus disease 2019 (COVID-19). *J Telemed Telecare*. Epub ahead of print 20 March 2020. DOI: 10.1177/1357633x20916567.