authors state that bony causes produced static winging which is present at rest and may be accentuated by certain passive shoulder movements.

Cooley & Torg (1982) described what they termed 'pseudowinging' of the scapula produced by subscapular osteochondroma. They stressed that although subtle points of differentiation might allow the diagnosis to be suspected, the condition was liable to be confused with classical winging produced by serratus anterior paralysis. Indeed, in the case described, the latter diagnosis had initially been made by two specialists and spontaneous resolution predicted.

In the case described above, radiology alone led to the correct diagnosis. The possibly misleading acute onset of symptoms was suggestive of a neurological cause. Also the winging was dynamic in that it was more prominent on asking the patient to push against a wall with both outstretched arms.

A plea is made for considering X-rays as part of the basic assessment of the apparently winged scapula.

ACKNOWLEDGMENTS

I wish to thank Karen Field of the Medical Photography Department of East Birmingham Hospital for the illustrations and Sally Mansell for typing skills.

A. BANERJEE

Senior Registrar,
Accident and Emergency Department,
East Birmingham Hospital,
Bordesley Green East,
Birmingham

REFERENCES

- Fiddian N. J. & King R. J. (1984) The winged scapula. *Clinical Orthopaedics* **185**, 228–236.
Colley L. H. & Torg J. S. (1982) 'Pseudowinging' of the scapula secondary to subscapular osteochondroma. *Clinical Orthopaedics* **162**, 119–124.

Bilateral pneumothoraces

Sir

I enjoyed the case report 'Beware spontaneous bilateral pneumothoraces' (Kendall *et al.*, 1992). Many accident and emergency (A&E) doctors, no doubt, will be aware of, and have seen cases of, bilateral pneumothoraces secondary to external blunt trauma. I wish to report a case of bilateral pneumothoraces presenting to an A&E department which was caused by intra-thoracic instrumentation.

A 57-year-old man, who was a non-smoker and generally fit and well, presented to his GP with a 3-week history of dry cough. A chest radiograph showed military shadowing of the lungs. Fibre-optic bronchoscopy with transbronchial biopsies

was performed as a daycase. Eight hours after the procedure, whilst at home, the patient developed acute severe breathlessness, and so he was taken to the A&E department. He was pink, tachypnoeic and mentally clear. There was not any asymmetry in signs on physical examination. Arterial gases and pH on 40% inspired oxygen were within normal range. Urgent portable chest radiograph revealed bilateral 50% pneumothoraces. His breathlessness was relieved by intercostal tube drainage on the right side, and needle aspiration on the left side. He was discharged home 5 days later. Biopsies subsequently demonstrated metastatic well-differentiated adenocarcinoma whose primary site proved to be colonic.

This case is noteworthy for two reasons. Firstly, early chest radiography led to definitive diagnosis and effective safe treatment, where lack of asymmetrical physical signs and normal arterial gases and pH were misleading. Secondly, although bilateral pneumothoraces secondary to intra-thoracic instrumentation may not be a rare event in thoracic units, A&E doctors need to be aware of the diagnosis in the acutely breathless patient with a history of recent day-case bronchoscopy.

M. SEDGWICK

Accident & Emergency Department,
Arrow Park Hospital,
Upton Road,
Upton,
Wirral