REFERENCES


Forced hyperextension to the wrist

Sir
A new pastime entitled ‘Mercy’ has come to our attention following the attendance of a 21-year-old student to the Accident and Emergency (A&E) department. The aim of this game is to inflict pain on the participating opponent by forced hyper-extension to the wrist until they cry ‘mercy’. Unfortunately, this young man sustained an undisplaced oblique fracture of the mid shaft of the third metacarpal whilst playing the game with his girlfriend.

Do any readers have experience of other such ‘mercy’ inflicted fractures?

A. DANCOKS & L. THEAN
Accident and Emergency Department,
Leicester Royal Infirmary,
Leicester

X-rays as a diagnostic aid in winged scapula

Sir
Winging of the scapula is a well-described clinical entity, with a variety of possible causes. A recent case of winged scapula is described in which an X-ray allowed the correct diagnosis to be made in the absence of any obvious clinical clues. As winging of the scapula is usually attributed to neurological causes on clinical grounds, potentially surgically treatable bony lesions responsible for winging may be under-recognized.

A 34-year-old male amateur golfer attended the accident and emergency (A&E) department with left (non-dominant) shoulder pain. This pain developed suddenly following a stroke with a golf club 3 days previously. He did not recall any direct impact to the shoulder. On returning home his wife commented on obvious prominence of his left scapula. He denied any previous symptoms related to either shoulder. He was otherwise in good health.

On examination, obvious winging of the left scapula was observed. This winging was present even with the left arm held by the side but became more obvious on pushing forwards against a wall. There was a full range of pain-free movement in the left shoulder. An X-ray was obtained by a process of default, as there was no history of direct trauma and no local bruising or mass was discernible. The X-rays
Fig. 1. AP view of left shoulder showing osteochondroma.

Fig. 2. Oblique projection of left scapula.

(Figs 1 & 2) showed a calcified lesion arising from the body of the scapula. The appearances were consistent with the diagnosis of osteochondroma.

He was subsequently referred to an orthopaedic surgeon for surgical removal of the lesion. The diagnosis was confirmed histologically. On further examination after the X-rays were obtained no other bony lumps were found in the axial or appendicular skeleton. Complete recovery ensued.

Winging of the scapula can be produced by one of a variety of causes. These causes have been classified into four types, according to whether the primary defect is in the nerve supply, muscle, bone or joint (Fiddian & King, 1984). These
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


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 miliary shadowing of the lungs. Fibre-optic bronchoscopy with transbronchial biopsies